OPTIONAL/ALTERNATIVE RETIREMENT PLAN HEALTH INSURANCE CREDIT EMPLOYER CERTIFICATION OF SERVICE

VIRGINIA RETIREMENT SYSTEM
P.O. Box 2500 ◆ Richmond, Virginia 23218-2500
Toll Free 1-888-VARETIR (827-3847)
www.varetire.org

1. **Social Security Number**
2. **Employer Code**

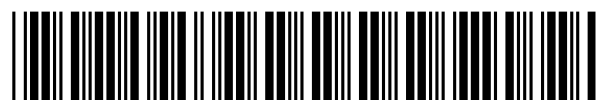
The employer completes this form to certify the participant's eligibility for a health insurance credit. VRS determines the amount of the credit to be paid. If this form is not completed and sent to VRS, the health insurance credit cannot be paid to the eligible Optional Retirement Plan/Alternative Retirement Plan (ORP/ARP) participant.

This form is for initial enrollment into the health insurance credit program. In the future, the participant must notify VRS of changes to the health insurance coverage information by completing the Request for Health Insurance Credit (VRS-45), which is available on the VRS Web site (www.varetire.org).

PART A. PARTICIPANT INFORMATION

3. **Name** (First, Middle Initial, Last)	
4. **Address** (Street, City, State and Zip+4)	
5. **Birth Date**	6. **Daytime Phone Number**
7. **Gender** ❑ Male ❑ Female	8. **Participant Status** ❑ ORP/ARP long-term disability (LTD) recipient ❑ ORP/ARP retiree
9. **Is the participant covered by Part B of Medicare?** ❑ Yes ❑ No If yes: a) Enter the effective date of Medicare: __________________ (mm/dd/yyyy) b) Enter the premium amount: $__________________/month	

If the participant does not have insurance other than Medicare, continue to Part C of this form.
To report another insurance policy, continue to Part B.



10. SSN

PART B. INSURANCE POLICY INFORMATION

If the participant has health, dental, vision, or prescription drug insurance, complete boxes 11 and 12 about that policy.

11. If the policy is a Commonwealth of Virginia (COVA) Health Benefit Plan, enter the plan name: ______________________

If not, enter the following information from the current health insurance card:

Plan Name: ______________________

Address: ______________________

____

Membership Type (Choose one):

❑ Single ❑ Two People ❑ Family

Policy Number: ______________________

12. Premium Information

a) How many times per year is the insurance premium paid? ______________

b) How much is each premium payment? $ ______________

c) How much of each payment pays the retiree's portion of the coverage? $ ______________

d) What is the effective date of this premium amount? ______________

PART C. CERTIFICATION

13. For ORP/ARP retiree, provide the following:

Name of Retirement Plan

____

ORP Plan Number: ______________________

Date of First Distribution: ______________________

Years and Months of Service: ______________________

14. For ORP/ARP long-term disability recipient, provide the following:

LTD Start Date: ______________________

Projected LTD End Date: ______________________

Years and Months of ORP/ARP Service (if over 30 years): ______________________

15. Employer Certification: I certify this individual was an employee with this agency who 1) is receiving long-term disability benefits, or 2) has started a periodic retirement distribution or purchased an annuity from a qualified Optional or Alternative Retirement Plan; and has a minimum of 15 years of creditable service. The type of employment, position held, and the period of service as provided above meets eligibility requirements for the health insurance credit.

______________________ ______________________

Authorized Signer (Please print) Title

______________________ ______________________ ______________________

Signature Phone Number Date

16. Participant Certification: If I am an ORP/ARP retiree, I certify that I will begin receiving distributions from my plan as indicated in box 13. I understand that I am responsible for repaying any overpayment of the health insurance credit. VRS may invoice me for the overpayment and, upon my death or claim for accelerated life insurance benefits, any remaining balance will be recovered from the proceeds of my group life insurance coverage. I also understand that I must immediately report any change in health insurance coverage to VRS.

______________________ ______________________

Participant Signature Date

INSTRUCTIONS FOR COMPLETING THE ORP/ARP HEALTH INSURANCE CREDIT EMPLOYER CERTIFICATION

Part A. Participant Information

Boxes 2-7: Enter the participant's personal information.

Box 8: Check the appropriate box to let VRS know whether the participant is an ORP/ARP retiree or long-term disability recipient.

Box 9: If the participant is covered by Medicare, choose Yes and include the effective date of his or her Medicare Part B coverage and the premium amount paid each month.

Part B. Participant's Insurance Policy Information

If the participant has health, dental, vision, or prescription drug insurance coverage, complete Part B. If the participant has more than one policy, attach a separate sheet with the additional policy information. **Note:** Policies *not* eligible for reimbursement include long-term disability, home health care, long-term care, dread disease (such as cancer), hospital indemnity, life insurance or policies that restrict payment of benefits that treat specific illnesses.

To complete Part B, enter the following information from the current policy. (Do not include information from policies that are no longer in effect or that are not eligible for reimbursement.)

Box 11: If the policy is an employer-sponsored Commonwealth of Virginia (COVA) Health Benefit Plan administered by the Department of Human Resource Management, enter the plan name. (Example: Advantage 65)

If the policy is not a COVA policy, use the participant's current insurance card to enter the name and address of the provider, the membership type the participant selected, and the policy number.

Box 12: Answer the four questions about the premium that is paid for the insurance policy in Box 11. Indicate the number of times each year you pay the premium, the total amount of each payment, how much of that amount is for your portion of the policy, and the date when this premium amount became effective.

Part C. Certification

Box 13: If the participant is an ORP/ARP retiree, provide the name and plan number of the qualified ORP/ARP from which the participant elected to receive a periodic distribution or purchased an annuity, the date that periodic distributions will begin, and the years and months of creditable service which will be used to determine eligibility for the health insurance credit.

Box 14: If the participant is an ORP/ARP long-term disability benefit recipient, enter the date approved for long term disability benefits, the projected date the benefit will end, and the total years and months of service if over 30 years. (A health insurance credit reimbursement of up to a maximum of $120 is allowed if the participant has 30 years of service or less at the time of entry into long-term disability. For those with more than 30 years of service, the health insurance credit will be paid based on the total years of service which may be a higher amount.) **Note:** The dates are critical to determine whether the health insurance credit benefit is overpaid or underpaid.

Box 15: Complete the employer certification.

Box 16: Have the participant sign and date the form to certify he or she will return any overpaid health insurance credit.

Note: Boxes 15 and 16 must be completed in order for VRS to pay the health insurance credit.