

CERTIFICATION OF EMPLOYMENT FOR HEALTH INSURANCE CREDIT ELIGIBILITY

VIRGINIA RETIREMENT SYSTEM
P.O. Box 2500
Richmond, Virginia 23218-2500
Toll Free 1-888-VARETIR (827-3847)
Fax 804-786-9718
www.varetire.org

1. Employer Code
2. Social Security Number

PART A. RETIREE INFORMATION (Please print)

3. Name	(First)	(MI)	(Last)	(Jr./Sr.)
4. Address	(Street)	(City)	(State)	(Zip+4)
5. Daytime Phone Number				
6. Is the retiree covered by Part B of Medicare?				
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes: a) Enter the effective date of Medicare: _____ (mm/dd/yyyy)				
b) Enter the premium amount: \$ _____/month				

PART B. EMPLOYER CERTIFICATION OF EMPLOYMENT

I certify this person was employed in the following position(s) for the period reflected below. I certify the information below is true and accurate, and that any willful falsification of facts presented may result in prosecution for a Class I misdemeanor as provided by law.

<input type="checkbox"/> General Registrar	From: _____ Through: _____
<input type="checkbox"/> Employee of General Registrar	From: _____ Through: _____
<input type="checkbox"/> Treasurer	From: _____ Through: _____
<input type="checkbox"/> Commissioner of Revenue	From: _____ Through: _____
<input type="checkbox"/> Clerk of Circuit Court	From: _____ Through: _____
<input type="checkbox"/> Attorney for the Commonwealth	From: _____ Through: _____
<input type="checkbox"/> Sheriff	From: _____ Through: _____
<input type="checkbox"/> Sheriff's Deputy	From: _____ Through: _____
<input type="checkbox"/> Employee of Local Social Services Board	From: _____ Through: _____
<input type="checkbox"/> Employee of _____ (Constitutional Officer)	From: _____ Through: _____ (mm/dd/yyyy) (mm/dd/yyyy)

7. SSN

PART C. INSURANCE POLICY INFORMATION

8. 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: _____

Membership Type (Choose one):

Address: _____

Single Two People Family

Policy Number: _____

9. 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 D. INSURANCE POLICY INFORMATION (ADDITIONAL POLICY)

10. Enter policy information from the current health insurance card for policies other than those listed in Part A or C:

Plan Name: _____

Membership Type (Choose one):

Address: _____

Single Two People Family

Policy Number: _____

11. 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 E. CERTIFICATION

Retiree: I understand that I am responsible for repaying any overpayment of the health insurance credit. VRS may invoice me for the overpayment or recoup the amount from my VRS retirement benefit. In addition, I understand, upon my death or claim for accelerated life insurance benefits, that any remaining balance may also be recovered from the proceeds of my group life insurance coverage. VRS may also recover the overpayment from any refund of retirement contributions and interest payable upon my death. I certify the information I have provided on this document is true, and I understand that any willful falsification of facts presented may result in prosecution for a Class I misdemeanor as provided by law. I also understand that I must immediately report any change in health insurance coverage to VRS.

Retiree Signature _____ Date

Employer: The agency benefits administrator authorizes this form for all positions above *except* the "Employee of a Constitutional/Local Officer." If this box is checked, the constitutional officer to whom the employee reports authorizes this form.

Authorized Signer (Please print) _____ Title

Authorized Signature _____ Phone Number _____ Date



INSTRUCTIONS FOR COMPLETING THE CERTIFICATION OF EMPLOYMENT FOR HEALTH INSURANCE CREDIT ELIGIBILITY

Employers complete this form to certify the retiree's eligibility for the health insurance credit and to enroll the retiree in the health insurance credit program. All positions held under one employer code may be certified on the same form. (If the retiree has service with more than one employer, the retiree must have each employer submit a separate certification (the first page of this form). After processing the VRS-76 form(s), VRS will notify the retiree of his or her eligibility for the health insurance credit.

In the future, the retiree 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).

Retirees with 15 years of total service credit in the Virginia Retirement System (VRS) as a constitutional officer, an employee of a constitutional officer, an employee of a local social services board, as a general registrar or an employee of a general registrar, are eligible for the health insurance credit.

Part A. Retiree Information

Boxes 2-5: Enter the retiree's personal information.

Box 6: If the retiree 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. Employer Certification of Position(s)

Check each position the retiree held and enter the time period the retiree was in each position. (Enter the dates in mm/dd/yyyy format.)

Parts C and D. Insurance Policy Information

If the retiree has health, dental, vision, or prescription drug insurance, complete Part C. If the retiree has more than one policy, provide the additional policy information in Part D.

Note: Policies *not* eligible for reimbursement include long-term disability, home health care, long-term care, dread disease (such as cancer), hospital indemnity or policies that restrict payment of benefits that treat specific illnesses.

To complete Part C (and/or Part D), enter the following information from the retiree's policy. (Do not include information from policies that are no longer in effect or that are not eligible for reimbursement.)

Box 8: 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 9: Answer the four questions about the premium that is paid for the insurance policy in Box 8. 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.

(If the retiree has a secondary medical insurance policy, complete Part D in same manner as Part C.)

Part E. Certification

Retiree: The retiree must certify they will return any overpaid health insurance credit.

Employer: Read and complete the certification and provide all necessary information.

Note: If the retiree was an employee of a constitutional officer, the constitutional officer must provide the authorized signature, rather than the employing agency's benefits administrator. All other positions, including constitutional officers, may be authorized by the benefits administrator.

When the form is complete, send the form to VRS at the address on the top of the form. VRS will retroactively reimburse up to a maximum of 12 months from the date the completed form is received by VRS as long as the necessary health insurance information has been provided. VRS is required by law to send all plan participants an annual reminder to keep their health insurance coverage information current.