REQUEST FOR HEALTH INSURANCE CREDIT

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

Clear Form

1. Social Security Number
2. Phone Number
3. Reason for Request ❑ New participant ❑ Change in health insurance premium or policy

Complete this form to request a health insurance credit or to notify VRS of changes to your insurance coverage and/or premium amount.

PART A. RETIREE INFORMATION (Please print)

4. Name (First, Middle Initial, Last)

5. Address (Street, City, State and Zip+4)

6. Are you covered by Part B of Medicare?

❑ Yes ❑ No If yes: a) Enter the effective date of Medicare Part B: _____ (mm/dd/yyyy)

b) Enter the current premium amount: $_____/month

Do you have other Medicare supplemental coverage? If so, enter that coverage in Part B or C of this form.

If you do not have insurance other than Medicare A and B, continue to the Retiree Certification (Part D).

PART B. INSURANCE POLICY INFORMATION

If you have health, dental, vision, or prescription drug insurance, complete boxes 7-9 about that policy.

7. 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: _____

8. 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? _____

9. Cancellation Date of Previous Policy (If applicable) (mm/dd/yyyy)

10. SSN

PART C. INSURANCE POLICY INFORMATION – ADDITIONAL POLICY

If you have health, dental, vision, or prescription drug insurance other than the policies listed in Part A or Part B of this form, complete boxes 11-13 about that policy.

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

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? _____

13. Cancellation Date of Previous Policy (If applicable) (mm/dd/yyyy)

PART D. RETIREE CERTIFICATION

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 will 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

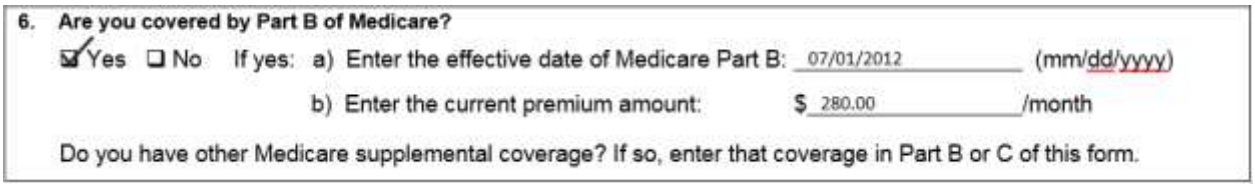
INSTRUCTIONS FOR COMPLETING THE REQUEST FOR HEALTH INSURANCE CREDIT

Note: You may need to complete additional forms if you are making changes on policies with different effective dates.

Part A. Retiree Information

Boxes 1-5: Enter your personal information.

Box 6: If you are covered by Medicare, choose Yes.


6. Are you covered by Part B of Medicare?
☑ Yes ☐ No If yes: a) Enter the effective date of Medicare Part B: 07/01/2012 (mm/dd/yyyy)
b) Enter the current premium amount: $ 280.00 /month
Do you have other Medicare supplemental coverage? If so, enter that coverage in Part B or C of this form.

If you choose yes, complete a) and b):

a) This is the date you started receiving Medicare Part B.
b) This is the amount you pay each month for your Medicare Part B coverage.

Parts B and C. Insurance Policy Information

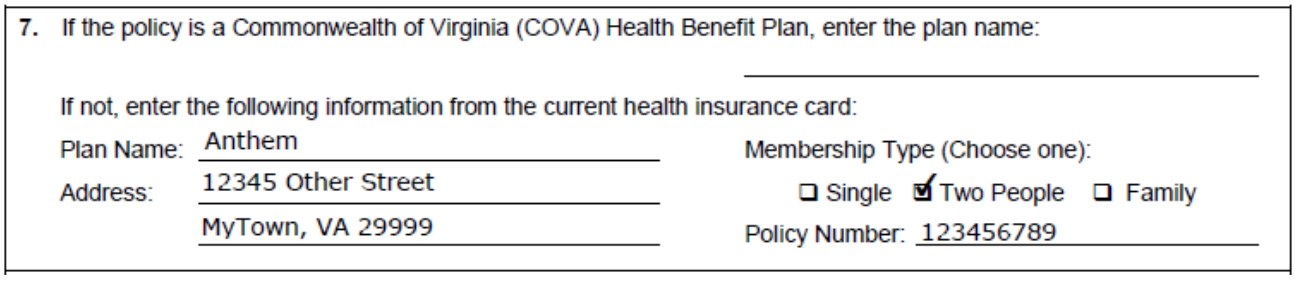
If you have health, dental, vision, or prescription drug insurance, complete Part B. If you have more than one policy, provide the additional policy information in Part C.

Note: Examples of policies *not* eligible for reimbursement include, but are not limited to, long-term disability, home health care, long-term care, dread disease (such as cancer), hospital or other indemnity policies, limited benefit plans, network discount programs, health care bill-sharing plans, or policies that restrict payment of benefits to the treatment of specific illnesses.

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

Box 7: If your 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 your policy is not a COVA policy, use your current insurance card to enter the name and address of the provider, the membership type you selected and the policy number.


7. 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: Anthem
Address: 12345 Other Street
MyTown, VA 29999
Membership Type (Choose one):
☐ Single ☑ Two People ☐ Family
Policy Number: 123456789

Box 8: Answer each question about the premium that is paid for the insurance policy in Box 7.

8. Premium Information	
a) How many times per year is the insurance premium paid?	12
b) How much is each premium payment?	$ 350.00
c) How much of each payment pays the retiree's portion of the coverage?	$ 175.00
d) What is the effective date of this premium amount?	7/1/2016

a) This is the number of times you pay the insurance premium. If you pay monthly, enter 12; annually, enter 1.

b) This is how much you pay for the insurance each time you pay a premium. If your annual premium is $3,600 and you pay the premium 12 times, you would enter $300.

When you determine this amount, remember to reduce the premium amount by any subsidies, premium rewards or other amounts that may be paid by your employer. For instance, a state retiree whose premium amount normally costs $237 per month and who also receives $34 per month through a premium reward would pay $203 out of pocket, so $203 would be entered here.

c) If you selected a Membership Type of "Single" in Box 7, then 8c is the same amount you entered in 8b.

As shown in the example above for Box 7, with a Membership Type of "Two People" (or "Family"), then this is the portion of the amount written in 8b that pays for only *your* coverage. For instance, you may have selected coverage for "Two People" and pay $350 per month, but only $175 of the premium goes toward paying for your portion of the coverage. In this case, $350 is reported in 8.b. and $175 is reported in 8.c.

If you are not covered by the State health benefits, you may need to consult your private health insurance company for this amount. For those covered by State health benefits, VRS will verify the cost of the State health benefits for "Two People" or "Family" coverage to ensure you receive your maximum health insurance credit eligibility.

d) This is the date the premium amount you entered in 8b became effective.

Box 9: Enter the cancellation date for the previous policy used to determine your health insurance credit if it applies.

(If you have a secondary medical insurance policy, complete Part C in the same manner as Part B.)

Part D. Retiree Certification

Sign and date in Part D after reading the certification statement. Send the completed 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 is provided. VRS reminds plan participants at least annually to notify VRS of any changes in coverage or premium amounts.