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

VIRGINIA RETIREMENT SYSTEM
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www.varetire.org

Clear Form

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 website (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. Phone Number**
7. Gender ❑ Male ❑ Female	**8. Participant Status** ❑ ORP/ARP long-term disability (LTD) recipient ❑ ORP/ARP retiree

PART B. EMPLOYER CERTIFICATION

9. For ORP/ARP retiree, provide the following: Name of Retirement Plan _____ ORP Plan Number: _____ Years and Months of Service: _____ Dates of Service: _____	**10. For ORP/ARP long-term disability recipient, provide the following:** LTD Start Date: _____ Projected LTD End Date: _____ Vendor: _____ Years and Months of ORP/ARP Service (if more than 30 years): _____ School Superintendent: ❑ Yes ❑ No

11. Employer Certification

I certify this individual was an employee with this agency who 1) is receiving long-term disability benefits, or 2) has retired 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

12. SSN

PART C. MEDICARE COVERAGE

13. 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

PART D. INSURANCE POLICY INFORMATION

14. 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: _____

15. 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. PARTICIPANT CERTIFICATION

16. Participant Certification: 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 1-7: 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.

Part B. Employer Certification

Box 9: If the participant is an ORP/ARP retiree, provide the name and plan number of the qualified ORP/ARP and the beginning and end dates of creditable service which will be used to determine eligibility for the health insurance credit. If the participant purchased an annuity, submit a copy of the certificate with this form.

Box 10: 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, the name of the vendor providing the benefit, 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). Indicate whether the participant is a superintendent of schools. (School superintendents receive the lesser of $4 times twice the amount of service credit or $4 times the amount of service at age 60 if he or she had remained in service.) **Note:** The dates provided are critical in determining accurate payment of the health insurance credit benefit.

Box 11: Complete the employer certification.

Part C. Medicare Coverage

Box 13: If covered by Medicare, the participant chooses yes and included the effective date of his or her Medicare Part B coverage and the premium amount paid each month.

Part D. Insurance Policy Information

If the participant has health, dental, vision or prescription drug insurance coverage, he or she completes Part D. If the participant has more than one policy, a separate sheet with the additional policy information may be attached. **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, or policies that restrict payment of benefits to the treatment of specific illnesses.

To complete Part D, the participant enters 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 14: 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 (eg: Advantage 65). If the policy is not a COVA policy, the participant enters the name and address of the provider from the current membership card, the membership type, and the policy number.

Box 15: The participant answers the four questions about the premium that is paid for the insurance policy identified in Box 14. 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 E. Participant's Certification

Box 16: The participant signs and dates the form to certify he or she will return any overpaid health insurance credit.

Important: Boxes 11 and 16 must be completed in order for VRS to pay the health insurance credit.