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

VIRGINIA RETIREMENT SYSTEM
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Fax 804-786-9718
www.varetire.org

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

Clear Form

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) and changes to the direct deposit by completing the Authorization for Direct Deposit (VRS-57), which are available at www.varetire.org/forms.

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: _____

Employment Start Date: _____

Employment End Date: _____

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): _____

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, provide the following information:

Effective date of Medicare Part B: _____ (mm/dd/yyyy)

Current premium: ❑ $164.90 ❑ $230.80 ❑ $329.70 ❑ $428.60 ❑ $527.50 ❑ Other: $_____/month

PART D. INSURANCE POLICY INFORMATION

If the participant has health, dental, vision, or prescription drug insurance, complete Part C for each plan. Copy this page as necessary to report all additional policies.

14. Provider and Plan Name

15. Policyholder

❑ Self ❑ Spouse

16. Coverage Option

❑ Single ❑ Two ❑ Family

17. Policy Type

❑ Health ❑ Dental ❑ Vision ❑ Prescription Drug ❑ Other

18. 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 participant's portion of the coverage? $ _____

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

19. If the plan is *not* provided by the Commonwealth of Virginia (COV), enter the plan address:

20. Does this policy cancel a previous policy?

❑ Yes ❑ No, premium change only If Yes, enter the following:

Plan Name: _____ Cancellation date: _____

PART E. 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, total service, and the employment start and end dates which will be used to determine eligibility for the health insurance credit.

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). **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 the participant is covered by Medicare, choose Yes and provide the additional information: the date the participant started receiving Medicare Part B and the amount paid each month for the Medicare Part B coverage. If the amount paid is not listed, choose Other and enter the monthly amount.

Part D. Insurance Policy Information

If the participant has health, dental, vision, or prescription drug insurance, complete Part C for each policy.

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 D, enter the necessary information from each policy. (Do not include information from policies that are no longer in effect or that are not eligible for reimbursement.)

Box 14: Enter the plan name (e.g., Advantage 65)

Box 15: Indicate whether the participant or the participant's spouse is the policyholder.

Box 16: Indicate the coverage option

Box 17: Indicate the policy type

Box 18: Explain how the premium is paid:

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

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

When determining this amount, remember to reduce the premium amount by any subsidies, premium rewards or other amounts that may be paid by the 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 select the coverage option of “Single” in Box 16, then 18c is the same amount entered in 18b.

If the coverage option is “Two People” (or “Family”), then this is the portion of the amount written in 18b that pays for only *the participant’s* 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 the participant’s portion of the coverage. In this case, $350 is reported in 18b and $175 is reported in 18c.

If the participant is not covered by the State health benefits, he or she may need to consult the 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 the maximum health insurance credit is paid.

d) This is the date the premium amount entered in 18b became effective.

Box 19: If the policy is not a COV policy, please provide the address of the plan provider.

Box 20: Enter the cancellation date for the previous policy used to determine the health insurance credit if it applies.

Important: Boxes 14 through 20 must be completed for VRS to pay the health insurance credit.

Part E. Participant’s Certification

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