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 1-804-786-9718
www.varetire.org

1. Social Security Number
2. Employer Code

PART A. RETIREE INFORMATION (Please print)

3. Name	(First, Middle Initial, Last)
4. Address	(Street, City, State and Zip+4)
5. Daytime Phone Number	

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.

❑ General Registrar	From:______________________	Through:___________________
❑ Employee of General Registrar	From:______________________	Through:___________________
❑ Treasurer	From:______________________	Through:___________________
❑ Commissioner of Revenue	From:______________________	Through:___________________
❑ Clerk of Circuit Court	From:______________________	Through:___________________
❑ Attorney for the Commonwealth	From:______________________	Through:___________________
❑ Sheriff	From:______________________	Through:___________________
❑ Sheriff's Deputy	From:______________________	Through:___________________
❑ Employee of Local Social Services Board	From:______________________	Through:___________________
❑ Employee of ________________________ (Constitutional Officer)	From:______________________ (mm/dd/yyyy)	Through:___________________ (mm/dd/yyyy)

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

6. SSN

PART C. MEDICARE COVERAGE

7. Is the retiree 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

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 E. 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 F. 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 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

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

This form is used to enroll the retiree in the health insurance credit program. Employers complete Parts A and B of this form to certify the retiree's eligibility for the health insurance credit. 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.

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). The retiree completes the remainder of the form to identify health insurance information. 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 website at www.varetire.org.

Part A. Retiree Information

Boxes 1-5: Enter the retiree's personal information.

Part B. Employer Certification of Employment

The employer checks each position the retiree held and enters the time period the retiree was in each position. (Enter the dates in mm/dd/yyyy format.)

The employer reads and completes 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.

Parts C, D and E. Insurance Policy Information

The retiree completes the following:

Part C: If covered by Medicare, choose Yes and include the effective date of Medicare Part B coverage and the premium amount paid each month.

Parts D and E: If covered by other health, dental, vision, or prescription drug insurance, complete Part D. If covered by more than one policy, provide the additional policy information in Part E.

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 (and/or Part E), enter the following information from the 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 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 the premium is paid, 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 covered by a secondary medical insurance policy, complete Part E in same manner as Part D.)

Part E. Retiree Certification

The retiree must sign and date the form to certify that any overpaid health insurance credit will be returned.

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 reminds plan participants at least annually to notify VRS of any changes in coverage or premium amounts.