

REQUEST FOR HEALTH INSURANCE CREDIT



VIRGINIA RETIREMENT SYSTEM
P.O. Box 2500 ♦ Richmond, VA 23218-2500
Toll-free 1-888-827-3847
Fax 804-786-9718
www.varetire.org

1. Social Security Number
2. Phone Number
3. Reason for Request <input type="checkbox"/> New participant <input type="checkbox"/> 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.

Note: The information you provide on this form replaces all other insurance information at VRS and will be used to determine your health insurance credit.

PART A. RETIREE INFORMATION (Please print)

4. Name (First, Middle Initial, Last)
5. Address (Street, City, State and ZIP+4)
6. Are you a new ORP Retiree requesting your initial health insurance credit? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enter your retirement date: _____
7. Are you covered by Part B of Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the following information: Effective date of Medicare Part B: _____ (mm/dd/yyyy) Current premium: <input type="checkbox"/> \$135.50 <input type="checkbox"/> \$189.60 <input type="checkbox"/> \$270.90 <input type="checkbox"/> \$352.20 <input type="checkbox"/> \$433.40 <input type="checkbox"/> Other: \$_____/month

Report supplemental Medicare plans and other types of insurance other than Medicare A and B, in Part C.

PART B. RETIREE CERTIFICATION

<p>I understand that:</p> <ul style="list-style-type: none">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.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. <p>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.</p> <p>_____ Retiree Signature</p> <p>_____ Date</p>
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8. SSN

PART C. INSURANCE POLICY INFORMATION

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

9. Provider and Plan Name	
10. Policyholder <input type="checkbox"/> Self <input type="checkbox"/> Spouse	11. Coverage Option <input type="checkbox"/> Single <input type="checkbox"/> Two <input type="checkbox"/> Family
12. Policy Type <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Other	
13. 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 current effective date of this premium amount? _____	
14. If the plan is <i>not</i> provided by the Commonwealth of Virginia (COV), enter the plan address:	
15. Does this policy cancel a previous policy? <input type="checkbox"/> Yes <input type="checkbox"/> No, premium change only If Yes, enter the following: Plan Name: _____ Cancellation date: _____	

ADDITIONAL POLICY

16. Provider and Plan Name	
17. Policyholder <input type="checkbox"/> Self <input type="checkbox"/> Spouse	18. Coverage Option <input type="checkbox"/> Single <input type="checkbox"/> Two <input type="checkbox"/> Family
19. Policy Type <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Other	
20. 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 current effective date of this premium amount? _____	
21. If the plan is <i>not</i> provided by the Commonwealth of Virginia (COV), enter the plan address:	
22. Does this policy cancel a previous policy? <input type="checkbox"/> Yes <input type="checkbox"/> No, premium change only If Yes, enter the following: Plan Name: _____ Cancellation 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 a VRS retiree, choose No. If you are an Optional Retirement Plan (ORP) retiree, select Yes and enter your retirement date.

Box 7: If you are covered by Medicare, choose Yes and provide the additional information: the date you 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 B. Retiree Certification

Sign and date 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.

Remember: Notify VRS of any changes in coverage or premium amounts annually to ensure you receive the maximum health insurance credit available to you.

Part C. Insurance Policy Information

If you have 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 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 9: Enter the plan name (e.g., Advantage 65)

Box 10: Indicate whether you or your spouse is the policyholder.

Box 11: Indicate the coverage option

Box 12: Indicate the policy type

Box 13: 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 you pay for the insurance each time premium is paid. If the annual premium is \$3,600 and you pay 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 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 the coverage option of “Single” in Box 11, then 13c is the same amount entered in 13b.

If the coverage option is “Two People” (or “Family”), then this is the portion of the amount written in 13b 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 13b and \$175 is reported in 13c.

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 the maximum health insurance credit is paid.

- d) This is the date the premium amount entered in 13b became effective.

Box 14: If the policy is not a COV policy, please provide the address of the plan provider.

Box 15: Enter the cancellation date for the previous policy used to determine the health insurance credit if it applies.

Note: If you have more than one policy to report, complete boxes 16-22 in the same manner. This page may be copied to provide additional policy information as necessary.