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 ❑ New participant ❑ Change in health insurance premium or policy

Clear Form

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. Retirement Date (Only complete if you retired from an Optional Retirement Plan – ORP)

7. Are you 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: ❑ $174.70 ❑ $244.60 ❑ $349.40 ❑ $454.20 ❑ $559.00 ❑ Other: $_____/month

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

PART B. 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.
- 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.
- 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

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
❑ Self ❑ Spouse

11. Coverage Option
❑ Single ❑ Two ❑ Family

12. Policy Type
❑ Health ❑ Dental ❑ Vision ❑ Prescription Drug ❑ 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 *not* provided by the Commonwealth of Virginia (COV), enter the plan address:

15. Does this policy cancel a previous policy?

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

Plan Name: _____ Cancellation date: _____

ADDITIONAL POLICY

16. Provider and Plan Name

17. Policyholder
❑ Self ❑ Spouse

18. Coverage Option
❑ Single ❑ Two ❑ Family

19. Policy Type
❑ Health ❑ Dental ❑ Vision ❑ Prescription Drug ❑ 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 *not* provided by the Commonwealth of Virginia (COV), enter the plan address:

22. Does this policy cancel a previous policy?

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

Plan Name: _____ Cancellation date: _____

INSTRUCTIONS FOR COMPLETING THE REQUEST FOR HEALTH INSURANCE CREDIT

Complete this form to request your initial health insurance credit or to notify VRS of changes to your insurance coverage and/or premium amount. (If you retired from a position covered by VRS and you are currently receiving a monthly benefit, you can update your health insurance premiums online at myVRS.varetire.org rather than completing this form.)

Keeping your information current ensures you receive the proper credit amount and are not at risk for receiving an overpayment, which would require you to reimburse VRS.

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: Please enter your retirement date if you were a political appointee, or a school superintendent or were employed with an institution of higher education and you elected to participate in an Optional Retirement Plan (ORP).

If you retired from a position covered by VRS, leave retirement date blank.

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.

Part C. Insurance Policy Information

If health-related policy premiums are being paid by or for you, complete Part C for each policy.

Note: The following plans are examples of plans not eligible for the health insurance credit:

- Health care sharing ministries or cooperatives
- Direct primary care arrangements such as concierge medicine
- Life Insurance

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.