

REQUEST FOR HEALTH INSURANCE CREDIT

VIRGINIA RETIREMENT SYSTEM
 P.O. Box 2500
 Richmond, Virginia 23218-2500
 Phone 804/649-8059 Fax 804/786-9718
 Toll Free 1/888/VARETIR (827-3847)
 www.varetire.org

1. Social Security Number
2. Daytime Phone Number
3. Reason for request <input type="checkbox"/> New participant <input type="checkbox"/> Change in health insurance premium <input type="checkbox"/> Change in policy

See the back of this form for instructions and additional information.

PART A. RETIREE INFORMATION (Please print)

4. Name (First) (MI) (Last) (Jr./Sr.)			
5. Address (Street) (City) (State) (Zip)			
6. Check the appropriate box: <input type="checkbox"/> I am on VSDP long-term disability. <input type="checkbox"/> I am a VRS retiree.	7. Are you covered by a Medicare Part B Policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enter the effective date of the policy: _____ <div style="text-align: right;">(mm/dd/yyyy)</div>		

PART B. INSURANCE POLICY INFORMATION

8. Provider Name	9. Monthly Premium Amount \$
10. Provider Address	11. Does this policy cover other family members? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what portion of the premium is for <i>your</i> coverage only? \$_____
12. Policy Number	13. Effective Date of Policy or Premium Amount Change (mm/dd/yyyy)

PART C. INSURANCE POLICY INFORMATION (ADDITIONAL POLICY)

14. Provider Name	15. Monthly Premium Amount \$
16. Provider Address	17. Does this policy cover other family members? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what portion of the premium is for <i>your</i> coverage only? \$_____
18. Policy Number	19. Effective Date of Policy or Premium Amount Change (mm/dd/yyyy)

PART D. RETIREE CERTIFICATION

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.

 Retiree Signature

 Date



INSTRUCTIONS FOR COMPLETING THE REQUEST FOR HEALTH INSURANCE CREDIT

Complete this form to request a health insurance credit or to notify VRS of changes to your insurance coverage and premium amount. (Use additional forms to make multiple changes on policies with different effective dates.)

Part A. Retiree Information

- ✓ Complete Boxes 1 through 5 with your personal information.
- ✓ Complete Box 6 by checking the appropriate box to let VRS know whether you are on VSDP long-term disability or that you are a VRS retiree.
- ✓ Complete Box 7 if you are covered by Medicare. Include the effective date of your Medical Part B coverage.

Parts B and C. Insurance Policy Information

If you have a personal health insurance policy (medical/surgical) other than Medicare, complete Part B. If you have more than one personal health insurance policy, provide the additional policy information in Part C. Policies *not* eligible for reimbursement include long-term disability, dread disease (such as cancer), hospital indemnity or policies that restrict payment of benefits that treat specific illnesses.

If you are covered by Medicare *only*, do not complete Part B or Part C unless you pay a higher premium amount to Social Security for Medical Part B due to deferred enrollment in Medicare.

To complete Part B (and/or Part C), enter the following information from your new or current policy. (Do not include information from policies that are no longer in effect or that are not eligible for reimbursement.)

- ✓ In Box 8, enter the provider's name.
- ✓ In Box 9, enter the monthly premium amount that you pay for your insurance or premium amount you are reporting due to a premium change.
- ✓ In Box 10, enter the provider's address.
- ✓ In Box 11, check the appropriate box to let VRS know whether the policy covers other family members.
If you check Yes, provide the amount of the monthly premium you pay for your portion of the coverage. If you cannot determine your portion of the premium VRS will reimburse your health insurance credit amount based on the lesser of the health insurance credit amount or one half of the total premium amount listed in Box 9.
- ✓ In Box 12, enter the policy number.
- ✓ In Box 13, enter the effective date of the policy if it is the first time you will receive a health insurance credit, or enter the effective date that your premium amount changed if you have an existing policy.

(If you have a secondary medical insurance policy, complete Part C in same manner as Part B.)

Part D. Retiree Certification

Provide your signature and enter the date in Part D. 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.

VRS is required by law to send all plan participants an annual reminder to keep their health insurance coverage information current.