KENTUCKY PUBLIC PENSIONS AUTHORITY
1260 Louisville Road • Frankfort, KY 40601
Phone: (502) 696-8800 • Fax: (502) 696-8822 • kyret.ky.gov

Form 6260

Employer Certification of Health Insurance for Medical Reimbursement

The following sections are to be completed by Personnel and/or Benefits Administrator. All questions must be answered in order for this form to be valid.

Employee's Name:	Employee's Social Security Number:
Relation to Retiree:	If the spouse is the plan holder, does the employer pay any or all of the cost of the member's insurance coverage? ☐ Yes ☐ No

Medical Insurance Policy Information

Company Name:			Policy Number:
Company Address:			Company Phone:
City:	State:	Zip Code:	Monthly Insurance Premium:

Please list the individuals covered under this policy:

Name	Social Security Number	Relationship	Date of Birth	Gender	Tobacco Usage*	Insurance Effective Date	Insurance Termination Date

**"Tobacco" means all tobacco products including, but not limited to, cigarettes, pipes, chewing tobacco, snuff, dip, cigars, and any other tobacco products regardless of the method of use.*

When are premiums paid? ☐ In Advance ☐ In Arrears

Insurance Effective Date	Insurance Termination Date	Level of Coverage	Premium Owed	Cost of Single Coverage	Amount Paid by Employee	Date Paid

Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

I certify that all the information completed on this form is true and accurate. I understand that there is penalty under Kentucky Law (KRS 523.100) for falsification of records.

Position Title: _____ Telephone Number: _____

Signature of Authorized Representative: _____ Date: _____

Return to: Kentucky Public Pensions Authority, 1260 Louisville Road, Frankfort, KY 40601-6124
Please call 1-800-928-4646 with questions.