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

Print Form

**Form 6282**
09/2022

# Insurance Agent/Company Certification of Health Insurance for Dollar Contribution Reimbursement Plan

| **This section to be completed by KPPA member.** | | | |
|---|---|---|---|
| Member Name: | | Member ID: | |
| Address: | City: | State: | Zip Code: |
| Daytime Phone: | Other Phone: | | |

Kentucky law provides for the reimbursement of hospital and medical insurance premiums for recipients of a retirement allowance who are eligible for the dollar contribution health insurance benefit and are not enrolled in a health insurance plan through the Kentucky Public Pensions Authority (KPPA). The recipient shall be eligible for reimbursement of substantiated medical insurance premiums for their earned service dollar contribution rate determined in accordance with KR 61.702(4)(d) and KRS 78.5536(4)(d). The KPPA will reimburse eligible recipients who have submitted all required forms and documentation once each calendar year quarter. Pursuant to 105 KAR 1:411 proof of payment of medical insurance premiums for the requested time period is required to determine the recipient's eligibility for reimbursement under the dollar contribution reimbursement for medical insurance premiums plan. This fully completed form can satisfy this requirement.

I wish to be reimbursed for my medical insurance premiums. I hereby authorize the release of all pertinent medical insurance information to the KPPA for this purpose.

Signature: _____ Date: _____

| **This rest of this form should be completed by Agent or Authorized Representative of Insurance Company. All questions must be answered in order for this form to be valid.** | | | |
|---|---|---|---|
| Policy holder Name: | | | |
| Policy holder Social Security Number: | | Relation to Member: | |
| **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 | Insurance Effective Date | Gender | Tobacco Usage* |
|---|---|---|---|---|---|---|
| | | | | | | |
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*"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.

## Insurance Agent/Company Certification of Health Insurance for Health Insurance Reimbursement Plan

**Medical Insurance Policy Information *continued***

When are premiums paid? ☐ In Advance ☐ In Arrears

KPPA will not reimburse eligible members until the covered period has expired

In accordance with KRS 61.702(6), KRS 78.5536(6) and 105 KAR 1:411, KPPA will reimburse eligible recipients on a quarterly basis.

Please complete the following payment history for the applicable quarter.

| **1st Quarter** | **Year** | **Level of Coverage** | **Premium Owed** | **Cost of Single Coverage** | **Amount Paid by Member** | **Date Paid** |
|---|---|---|---|---|---|---|
| January | | | | | | |
| February | | | | | | |
| March | | | | | | |
| **2nd Quarter** | **Year** | **Level of Coverage** | **Premium Owed** | **Cost of Single Coverage** | **Amount Paid by Member** | **Date Paid** |
| April | | | | | | |
| May | | | | | | |
| June | | | | | | |
| **3rd Quarter** | **Year** | **Level of Coverage** | **Premium Owed** | **Cost of Single Coverage** | **Amount Paid by Member** | **Date Paid** |
| July | | | | | | |
| August | | | | | | |
| September | | | | | | |
| **4th Quarter** | **Year** | **Level of Coverage** | **Premium Owed** | **Cost of Single Coverage** | **Amount Paid by Member** | **Date Paid** |
| October | | | | | | |
| November | | | | | | |
| December | | | | | | |

Insurance Company/Agency Name: _____

Insurance Company/Agency Address: _____

City: _____ State: _____ Zip Code: _____

I certify that all the information completed on this form is true and accurate. I acknowledge that I have full understanding that any person who provides a false statement, report, or representation to a governmental entity such as KPPA is subject to the penalty of perjury in accordance with KRS 523.010, et seq. I further acknowledge that if I knowingly submit or cause to be submitted a false or fraudulent claim for the payment or receipt of benefits, including reimbursements, the employer I represent and I (personally) may be liable for restitution of the reimbursement the member/beneficiary/recipient listed on this form was not eligible to receive, civil payments, legal fees, and costs.

Position Title: _____ Telephone Number: _____

Signature of Authorized Representative/Agent: _____ Date: _____

**You may upload this form through Retiree Self Service at myretirement.ky.gov. Or you may return the form to: Kentucky Public Pensions Authority, 1260 Louisville Road, Frankfort, KY 40601**