



Employer 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:		<input type="checkbox"/> Please check this box if your spouse is the plan holder.	

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 KRS 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 recipients 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: _____

The rest of this form is 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 Member:		If the spouse is the plan holder, does the employer pay any or all of the cost of the member's insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what is the amount paid per month?			

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*

*"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.

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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, the 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 Employer*	Employer Contribution for Member Coverage	Amount Paid by Employee	Date Paid
January								
February								
March								
2nd Quarter	Year	Level of Coverage	Premium Owed	Cost of Single Coverage	Amount Paid by Employer*	Employer Contribution for Member Coverage	Amount Paid by Employee	Date Paid
April								
May								
June								
3rd Quarter	Year	Level of Coverage	Premium Owed	Cost of Single Coverage	Amount Paid by Employer*	Employer Contribution for Member Coverage	Amount Paid by Employee	Date Paid
July								
August								
September								
4th Quarter	Year	Level of Coverage	Premium Owed	Cost of Single Coverage	Amount Paid by Employer*	Employer Contribution for Member Coverage	Amount Paid by Employee	Date Paid
October								
November								
December								

*105 KAR 1:411 states that the reimbursement rate shall be reduced by the amount contributed by an employer toward the recipient's insurance premiums.

Employer Name: _____

Employer 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 benefit, including reimbursements, the employer I represent and I (personally) may be liable for restitution of the reimbursements 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: _____ 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**