Kentucky Retirement Systems
Perimeter Park West •1260 Louisville Rd. • Frankfort KY 40601-6124
Phone: (502) 696-8800 • Fax: (502) 696-8822 • kyret.ky.gov

Print Form

Form 6241
Revised 07/2011

Employer Certification of Health Insurance for Health Insurance Reimbursement Plan

This section to be completed by KRS member.

Member Name:		Member ID:	
Address:	City:	State:	Zip Code:
Daytime Phone:	Other Phone:	☐ 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 not eligible for the same level of hospital and medical benefits as recipients living in Kentucky and having the same medical insurance eligibility status. The recipient shall be eligible for reimbursement of substantiated medical insurance premiums for an amount not to exceed the monthly premium determined in KRS 61.702(3). If the recipient is a nonhazardous retiree, the recipient will only be reimbursed the cost of single coverage up to the allowable maximum. The retirement office will reimburse eligible recipients once each calendar year quarter. Pursuant to 105 KAR:1:290 the following information is required to determine the retired member's eligibility for reimbursement under the medical insurance reimbursement plan.

I wish to be reimbursed for my medical insurance premiums. I hereby authorize the release of all pertinent medical insurance information to the Kentucky Retirement Systems 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 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
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	Effective Date of Coverage	Gender

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Medical Insurance Policy Information *continued*

When are premiums paid? ☐ In Advance ☐ In Arrears

KRS will not reimburse eligible members until the covered period has expired.

In accordance with KRS 61.702 (7), the Kentucky Retirement Systems will reimburse eligible recipients on a quarterly basis. If the recipient is a nonhazardous retiree, the recipient will only be reimbursed the cost of single coverage up to the allowable maximum.

Please complete the following payment history for the applicable quarter.

	Year	Level of Coverage	Premium Owed	Cost of Single Coverage	Amount Paid by Employer*	Employer Contribution for Retiree Coverage	Amount Paid by Employee	Date Paid
1st Quarter								
January								
February								
March								
2nd Quarter	**Year**	**Level of Coverage**	**Premium Owed**	**Cost of Single Coverage**	**Amount Paid by Employer***	**Employer Contribution for Retiree 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 Retiree 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 Retiree Coverage**	**Amount Paid by Employee**	**Date Paid**
October								
November								
December								

*105 KAR 1:290 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 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 Retirement Systems, Perimeter Park West, 1260 Louisville Road, Frankfort, KY 40601-6124
Please call 1-800-928-4646 with questions.