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

Print Form

Form 6241
Revised 09/2022

Employer Certification of Health Insurance for Health Insurance Reimbursement Plan

This section to be completed by KPPA 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, KRS 78.5536 and 105 KAR 1:411.

The Kentucky Public Pensions Authority (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 out of state 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 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?	☐ 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	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)(a)1, KRS 78.5536(6)(a)1, and 105 KAR 1:411, KPPA will reimburse eligible recipients on a quarterly basis. If the recipient is a nonhazardous member, 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.

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