



**Insurance Agent/Company
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:	

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. If the recipient is a nonhazardous retiree, the recipient will only be reimbursed the cost of single coverage up to the allowable maximum.

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 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	Effective Date of Coverage	Gender	Tobacco Usage*

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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, the KPPA 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.

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**