



City of Bristol Virginia

300 Lee Street
Bristol, VA 24201
Finance Department

1-276-821-6090

QUARTERLY - RETIREE STATEMENT OF INSURANCE COVERAGE

PART 1: INFORMATION

<input type="checkbox"/>	City Retiree	<input type="checkbox"/>	School Retiree
TODAYS DATE:		Retire Date:	
NAME OF RETIREE:			
ADDRESS:			
CITY, STATE, ZIP:			
PHONE #:		Email:	
SOCIAL SECURITY # (last 4 digits):	XXX - XX -	Date of Birth:	

PART 2: POLICY & PAYMENT VERIFICATION - QUARTERLY

The Quarter you are reporting: (Check One):	<input type="checkbox"/> January - March Year: _____	<input type="checkbox"/> April - June Year: _____	<input type="checkbox"/> July - September Year: _____	<input type="checkbox"/> October - December Year: _____
DEADLINE to submit to the City Finance Department:	April 15th	July 15th	October 15th	January 15th

No eligible retiree shall be paid more than the actual monthly cost of their health insurance (out-of-pocket). This benefit shall end on the date of an eligible retiree's qualification for Medicare eligibility (by age or disability) or his or her death, whichever shall first occur.

Proof of Payment:	Month/Year	Month/Year	Month/Year	Attach copies: 1. Proof of payments 2. If you have changed plans or canceled please contact the Finance Department at 1-276-821-6090
Total Premium paid. This amount is on the direct deposit or receipt.	\$	\$	\$	
Spouses portion:	\$	\$	\$	
Retiree's portion:	\$	\$	\$	

NOTE:

Failure to provide proof of insurance and payments will result in suspension of the monthly premium health benefit until proof can be provided.

Part 3: Medicare Eligible

Medicare Eligible is defined as supplement(s) Part A, B or D are offered either by reaching 65 years of age or Under 65 years of age and eligible by reason of disability.

If you are Medicare eligible please check the box, provide eligibility date, sign bottom of the form and submit back to our office.	If you are NOT Medicare Eligible, please check the box and complete Parts 2 & 3.
I am Medicare Eligible: <input type="checkbox"/>	I am NOT Medicare Eligible <input type="checkbox"/>
Date of Eligibility: _____ Turn 65 or Medicare Disability	

PART 4: RETIREE SIGNATURE

I certify the information I have provided on this document is true.
 I understand any willful falsification of facts presented may result in prosecution as provided by law.
 I understand I am required to report any changes at the time of the change.
 I understand if information is not provided by the due date, I will lose the benefit until the information is provided.
 I understand if I am Medicare Eligible, my benefit ceases.
 This benefit shall not be paid to any eligible retiree unless the retiree provides to the city proof of payment of their health insurance premium.

Signature: _____

Date: _____