

# ANNUAL PROOF OF INSURANCE VERIFICATION

## For the City of Bristol Virginia Retiree

Today's Date: \_\_\_\_\_

Retiree Name: \_\_\_\_\_

### Medicare Eligible

Medicare Eligible is defined as supplemental(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 turning Medicare Eligible during this reporting period, please check the box, provide eligible date, complete form, sign bottom and submit back to our office.

If you are NOT Medicare eligible this reporting period, please check the box below and complete this form.

I am or will be Medicare Eligible this reporting period:

I am Not Medicare Eligible \_\_\_\_\_

Date Eligible: \_\_\_\_\_

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 eligible (by age or disability) or his or her death, whichever shall first occur.

### Instructions:

Please provide proof of ANNUAL coverage. All information must be provided and signed. When signing this form, the Employer/Agent or Company is verifying the Retiree has a current insurance policy (Do Not include the employers cost of the premium). If insurance is online, no signature is required. Attach policy information.

Employer Name/Agent or Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Name & Title of person filling out this form : \_\_\_\_\_

Signature: \_\_\_\_\_

**Circle One: If separate policies, please fill out a form for each plan.**

Medical

Dental

Vision

Provider Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_

Relationship to Retiree: (circle one)

Self / Spouse

Cover Dependent: (If policy holder is not the Retiree)

Annual Start Date of Coverage: \_\_\_\_\_

Annual End Date of Coverage: \_\_\_\_\_

Type of Plan: (Circle one):

Self

Self +1

Family

Annual Out of Pocket of Expense

(Use ONLY Employee out of pocket expense. DO NOT include EMPLOYERS):

\$ \_\_\_\_\_

\$ \_\_\_\_\_

Use Self +1 out of pocket expense, not family.

Retiree's Annual Out of Pocket Expense :

\$ \_\_\_\_\_

Subtract Self from Self +1 if applies: (Do Not Include employers portion. Retiree can only claim the annual portion paid out of pocket)

Retiree's Monthly Out of Pocket Expense:

\$ \_\_\_\_\_

Divide Annual Out of Pocket Expense by 12

Number of Annual Deductions from Employer/Agent or Company: Circle One:

12

24

26

**Submit to: City of Bristol Virginia Finance Department - 300 Lee Street, Bristol VA 24201  
Phone 1-276-821-6090 & Fax 1-276-821-6085**

Office use: \_\_\_\_\_

Retiree's Monthly Benefit Amount: \_\_\_\_\_

Received: \_\_\_\_\_

Approved: \_\_\_\_\_

Declined: \_\_\_\_\_

Why: \_\_\_\_\_

Comment: \_\_\_\_\_