

Florida Retirement System (FRS)
Health Insurance Subsidy Certification for Investment Plan Retirees



P O Box 9000
Tallahassee FL 32315-9000
(850) 488-6491 Toll Free (888) 738-2252
Fax (850) 410-2195

**THIS FORM MUST BE COMPLETED AFTER YOU HAVE TERMINATED EMPLOYMENT
AND TAKEN A RETIREMENT DISTRIBUTION.**

Member Name _____	Member SSN _____
Applicant Name _____ If different	Applicant SSN _____ If different
Mailing address _____ _____ _____	Home Phone _____ Daytime Phone _____

Complete the section below, which will provide the earliest insurance policy date.

SECTION A: Former (non-state) employer or People First Service Center (1-866-663-4735) for state agencies

() This is to certify that _____ has health insurance coverage effective _____ and is currently covered through our agency.

Signature:FRS Agency Representative or People First Representative	Date	FRS Agency Name	Phone #
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SECTION B: Insurance Company

() This is to certify that _____ has health insurance coverage with _____ (Company Name). The effective policy date was _____.

Company Representative Signature	Date	Company Address	Phone #
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<p>SECTION C: MEDICARE or Military Insurance</p> <p>() I have attached either a MEDICARE or Military ID/TRICARE card.</p> <p>PLEASE DO NOT SEND YOUR ORIGINAL CARD. It will not be returned.</p> <p>NOTE: We will use your Medicare effective date to determine your HIS effective date. Your HIS effective date cannot be earlier than your Medicare effective date.</p>	<p>ATTACH COPY OF CARD HERE (MEDICARE OR MILITARY ID/TRICARE CARD)</p>
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