

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

PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888 FAX: 850-410-2010

The Health Insurance Subsidy (HIS) is a subsidy payment to retired members or a qualified beneficiary to assist in the payment of health insurance cost. The **HIS is not a health insurance policy**. Eligible retirees or beneficiaries will receive \$5 per month for each year of service credit earned. The payment is at least \$30 but not more than \$150 per month. The subsidy payment is contingent upon continued approval of the Florida Legislature.

TO BE ELIGIBLE FOR THE HIS YOU MUST MEET ALL OF THE FOLLOWING CRITERIA:

- You must meet the definition of termination by terminating employment and not becoming employed in any capacity with an FRS employer during the first six calendar months after your effective retirement date. Employment with any FRS employer during the seventh through twelfth calendar months after your effective retirement date will result in suspension of your health insurance subsidy benefits for the remainder of your reemployment limitation period. Exceptions for FRS retirees are outlined in Section 121.091(9), F.S. Prohibited employment includes full-time, part-time, temporary, other personal services (OPS), adjunct professors, poll workers, and contractual services.
- You must have the years of creditable service required to vest under the FRS Pension Plan.
- You must be retired, which means that you have taken a distribution from your FRS Investment Plan account other than a minimum required distribution or a mandatory de minimis distribution. A rollover of your FRS Investment Plan account to another qualified plan is a distribution.
- You must meet normal retirement by age or years of service under the FRS Pension Plan as defined in Section 121.021, F.S.
- You must have one of the following types of insurance coverage for the period during which you receive the subsidy payment: health; cancer; accident; disability; dental; vision; Medicare Part A and/or Part B; TRICARE; or military health coverage. Health coverage through Medicaid, Medically Needy Programs or the Health of the Brotherhood does not qualify as health insurance coverage for the HIS.

APPLICATION PROCESS:

To apply for the HIS, an FRS Investment Plan retiree who meets the eligibility criteria above or the qualifying beneficiary, must submit the HIS-IP, Application for Health Insurance Subsidy for Investment Plan Retiree along with the following information to the Division of Retirement (the division):

- The completed application form must be signed in the presence of a notary public.
- Certify your health insurance coverage to the division by properly completing form HIS-IP-2, Health Insurance Subsidy Certification for Investment Plan Retirees.
 - Medicare recipients may certify their health insurance coverage by completing Section C of the form HIS-IP-2 and attaching a photocopy of their signed Medicare card to the form.
 - TRICARE recipients may certify their health insurance coverage by completing Section C of the form HIS-IP-2 and attaching a photocopy of both sides of the Military Identification Card.
 - All other types of insurance coverage must be certified as provided in either Section A or B of the form.
- Proof of member's birth date - Proof of Birth must be legible. We will accept a photocopy of one of the following forms of proof except for "g," which requires photocopies of two of the items listed:
 - a. Copy of a birth certificate
 - b. Delayed birth certificate
 - c. Valid, unexpired U.S. passport
 - d. Census report more than 30 years old
 - e. Life insurance policy more than 30 years
 - f. If receiving Social Security benefits, a Benefit Letter from the Social Security Administration stating the date of birth it has established for the payment of benefits.
 - g. Certificate of Naturalization
 - h. Florida driver's license issued after January 1, 2010 that indicates compliances with the federal REAL ID Act
 - i. In the absence of one of the above, a document from **two** of the following categories will be required:
 - (1) Birth certificate of child, showing age of parent (limit one)
 - (2) Baptismal certificate more than 30 years old
 - (3) Hospital record of birth
 - (4) School record at time of entering grammar school
- A copy of the member's death certificate will be required if a qualified beneficiary is applying for the subsidy.

Note: If the member meets the above eligibility requirements, then the earliest the HIS payment could be payable is the month after taking a distribution, provided the division receives forms HIS-IP and HIS-IP-2 within six calendar months following the distribution. If the division receives the application and certification forms seven or more months after the member's distribution, the retroactive HIS payment will be limited to the maximum of six months. HIS payments shall not be subject to assignment, execution or attachment or to any legal process whatsoever.

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Member Name	_____	Member SSN	_____
Member Date of Birth	_____	Applicant SSN If different	_____
Applicant Name If different	_____	Home Phone	_____
Applicant Date of Birth	_____	Daytime Phone	_____
Applicant relationship to Member	_____	Applicant Email	_____
Mailing Address	_____ _____ _____		

I hereby make application for the Health Insurance Subsidy payment. I certify that I am terminated from all Florida Retirement System employers as of _____, certify that I have retired (taken a distribution other than a minimum required distribution or a mandatory de minimis distribution) from the Florida Retirement System Investment Plan on _____ and meet the vesting, normal retirement and other eligibility criteria.

The following individual may be contacted, if necessary, in the event of my death (This is not a beneficiary designation):

Name	_____	Relationship	_____
Mailing Address	_____ _____ _____		
Telephone	_____		

Applicant Signature: (sign in the presence of a Notary) _____

Notary: State of _____, County of _____. The above named person who has sworn to and subscribed before me this _____ day of _____ 20 _____ and is personally known _____ or produced _____ as identification.

Signature of Notary Public

Print, type, or Stamp Commissioned Name of Notary Public