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

P O Box 9000
Tallahassee FL 32315-9000
850 488-6491 Toll Free 888 738-2252

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. **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.

ELIGIBILITY:
In order to be eligible for the Health Insurance Subsidy you must meet all the following criteria:

- You must have terminated employment with all FRS participating employers.
- 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. A rollover of your FRS Investment Plan account to another qualified plan is a distribution.
- You 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 health insurance coverage, Medicare or TRICARE coverage for the period during which you receive the subsidy payment. Health coverage through Medicaid, Medically Needy Programs or the Health of the Brotherhood does not qualify as health insurance coverage for the Health Insurance Subsidy.

APPLICATION PROCESS:
The FRS Investment Plan retiree or his or her spousal beneficiary who meets the eligibility criteria above and wishes to receive the Health Insurance Subsidy must submit the following to the Division of Retirement **after terminating all employment with FRS employers and retiring from the FRS Investment Plan (taken a distribution or rollover):**

- Apply for the Health Insurance Subsidy on Form HIS-IP, Application for Health Insurance Subsidy for Investment Plan Retiree. This form must be properly completed, signed in the presence of a notary public and submitted to the Division of Retirement.
- Certify your health insurance coverage to the Division of Retirement 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. Birth Certificate
  b. Delayed birth certificate
  c. Census report more than 30 years old
  d. Life insurance policy more than 30 years old
  e. Letter from Social Security Administration stating the date of birth it has established for the payment of benefits
  f. Certificate of Naturalization
  g. 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 of Retirement receives Forms HIS-IP and HIP-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 ______________________________

Mailing Address ____

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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) 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 Florida, County of ______________________ The above named person has sworn to and

subscribed before me this ____________ day of ____________________20 ____ and is personally known ________

or produced ____as identification.

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Signature of Notary Public - State of Florida

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Print, type, or Stamp Commissioned Name of Notary Public