STRS Ohio Health Care PROGRAM

275 East Broad Street
Columbus, OH 43215-3771
1-888-227-7877
www.strsoh.org

VERIFICATION OF EMPLOYMENT AND EMPLOYER HEALTH CARE ACCESS FOR 2013

INSTRUCTIONS: Please read the introductory comments below. Then, complete this side of the form if you were employed in 2012, but WILL NOT be employed in 2013. Complete the opposite side if you anticipate being employed in 2013. Make sure you complete and sign only the side of the form that coincides with your anticipated employment status for 2013. Please return your completed form to STRS Ohio, Attn: Health Care Services Department, 275 E. Broad St., Columbus, OH 43215-3771.

Administrative Code Rule 3307:1-11-02 requires non-Medicare retirees enrolled in an STRS Ohio health care plan to provide information about their employment status and access to employer health care. This form, *Verification of Employment and Employer Health Care Access for 2013*, must be filed by all non-Medicare benefit recipient health care program enrollees if health care coverage is available through your employer, and if:

- You already returned to employment and have not completed a 2013 verification form;
- You anticipate returning to employment in 2013 and have not previously completed a verification form;
- You are continuing employment in 2013 but have now experienced a change in your employer-sponsored health care coverage; or
- You were employed in 2012 but will not be employed in 2013.

The information will be held in confidence to the extent permitted by law and will be used to assist in the proper administration of the STRS Ohio Health Care Program. **This form must be completed and returned to STRS Ohio. If you fail to comply with this Administrative Code Rule, your STRS Ohio health care coverage for 2013 will terminate 31 days from your employment start date.** For more information, we encourage you to read the STRS Ohio *Reemployment* brochure, available on our website at www.strsoh.org.

If you have questions, please call the STRS Ohio Member Services Center toll-free at 1-888-227-7877.

I WILL NOT BE EMPLOYED IN 2013.

Please read the information below, complete all blanks, sign and mail to STRS Ohio. Make sure you complete and sign only the side of the form that coincides with your anticipated employment status for 2013.

I hereby attest that I do not anticipate being employed in 2013 and that the information I have supplied on this form is complete and truthful. I understand that any false or incomplete information that I provide to STRS Ohio could result in the termination of my STRS Ohio health care coverage. I understand STRS Ohio may request additional supporting documentation at any time regarding my employment status and access to employer health care coverage and that in the event of such request, I will promptly provide such documentation.

If I become employed at a later date and I am still enrolled in an STRS Ohio health care plan, I will immediately inform STRS Ohio about the change in my employment status. I will then be required to complete a new *Verification of Employment and Employer Health Care Access* form. My failure to inform STRS Ohio may result in loss of coverage and repayment of health care premium subsidy and claim costs STRS Ohio has paid on my behalf.

In addition, by signing below I certify that I understand this verification form and that the form must be completed and returned to STRS Ohio. If I do not complete and return the form, my enrollment in the STRS Ohio Health Care Program for 2013 will terminate 31 days from my employment start date, which means I will not have medical and prescription drug coverage from STRS Ohio.

Benefit recipient's Social Security number
or STRS Ohio account number _____ Phone (_____)_____
Area code

Benefit recipient's name *(print)* _____

Benefit recipient's address _____
Street City State ZIP code

Email _____

Benefit recipient's signature _____ Date _____
Month/day/year

VERIFICATION OF EMPLOYMENT AND EMPLOYER HEALTH CARE ACCESS FOR 2013

INSTRUCTIONS: Complete and sign this side if you WILL be or anticipate being employed in 2013. (Complete the opposite side if you will not be employed in 2013.)

1. **Please provide the name, address and phone number of your anticipated 2013 employer, as well as your anticipated start date if you have not begun employment.**

   Employer name *(print)* _____ Anticipated start date _____ (Month/day/year)

   Employer address _____ (Street) (City) (State) (ZIP code)

   Phone (_____) _____ (Area code) Name of position held _____ Number of hours per week _____

2. **Does your employer contribute to any Ohio public retirement system? ❑ Yes ❑ No**

3. **Please answer both questions below regarding the health care coverage available through your anticipated 2013 employer.** (For more information regarding employment scenarios and a definition of "comparable positions," please review the STRS Ohio *Reemployment* brochure available online at www.strsoh.org or request a copy by calling STRS Ohio toll-free at 1-888-227-7877.)

   a. Is medical and prescription drug coverage available to individuals in "comparable positions" through your anticipated 2013 employer? ❑ **Yes** ❑ **No**

   b. Is the health care coverage available to individuals in "comparable positions" in 2013 at a cost equal to that offered to full-time employees at this employer? ❑ **Yes** ❑ **No**

   If you answered "no" to either question 3a or 3b, *stop here and skip below to the section "I ANTICIPATE I WILL BE EMPLOYED IN 2013."*

   If you answered "yes" to both questions 3a and 3b, you must enroll in your employer's plan within 31 days of your employment start date to be eligible to remain in an STRS Ohio health care plan. *If you do not enroll in your employer's plan, your coverage will terminate the first of the month following your employment start date.*

4. **Do you want to remain enrolled in your STRS Ohio health care plan with secondary coverage? Your only plan option is the Medical Mutual Basic or Plus Plan. Your employer plan will provide primary coverage. ❑ No ❑ Yes** *(If "yes," please provide the information requested below for your employer plan.)*

   Effective date of coverage _____ (Month/day/year) Is your spouse covered by your employer? ❑ **Yes** ❑ **No**
   Are other dependents covered by your employer? ❑ **Yes** ❑ **No**

   Health plan administrator _____ (For example, United) Health plan name _____ (For example, Choice Plan)

   Group ID # for plan _____ Individual ID # for plan _____

I ANTICIPATE I WILL BE EMPLOYED IN 2013.

Please read the information below, complete all blanks, sign and mail to STRS Ohio. Make sure you complete and sign only the side of the form that coincides with your anticipated employment status for 2013.

I hereby attest that the information I have supplied on this form is complete and truthful. I understand that any false or incomplete information that I provide to STRS Ohio could result in the termination of my STRS Ohio health care coverage. I understand STRS Ohio may request additional supporting documentation at any time and that in the event of such request, I will promptly provide such documentation.

If I answered "no" to questions 3a or 3b or if my employment status changes in the future, I may be eligible to enroll in an STRS Ohio health care plan with primary coverage; however, I acknowledge that it will be my responsibility to contact STRS Ohio to learn about enrollment and eligibility rules. If my employment status changes, I will immediately inform STRS Ohio about the change and I will be required to complete a new *Verification of Employment and Employer Health Care Access* form. My failure to contact and inform STRS Ohio may result in loss of coverage and repayment of health care premium subsidy and claim costs STRS Ohio has paid on my behalf.

In addition, by signing below, I certify that I understand this verification form and that the form must be completed and returned to STRS Ohio regardless of my employment status. If I do not complete and return the form, my enrollment in the STRS Ohio Health Care Program for 2013 will terminate 31 days from my employment start date, which means I will not have medical and prescription drug coverage from STRS Ohio.

Benefit recipient's Social Security number or STRS Ohio account number _____ Phone (_____) _____ (Area code)

Benefit recipient's name *(print)* _____

Benefit recipient's address _____ (Street) (City) (State) (ZIP code)

Email _____

Benefit recipient's signature _____ Date _____ (Month/day/year)