HIS-IP-2
Rev 10/11
Calculations

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 #

SECTION B: Insurance Company

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

Company Representative Signature | Date | Company Address | Phone #

SECTION C: MEDICARE or Military Insurance

( ) I have attached either a MEDICARE or Military ID/TRICARE card.

PLEASE DO NOT SEND YOUR ORIGINAL CARD. It will not be returned.

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.

ATTACH COPY OF CARD HERE (MEDICARE OR MILITARY ID/TRICARE CARD)