ARIZONA STATE RETIREMENT SYSTEM (ASRS)
REIMBURSEMENT OF MEDICAL AND/OR DENTAL COST
INSTRUCTIONS (SIX-MONTH REIMBURSEMENT PROGRAM)

The ASRS provides a Health Insurance Premium Benefit (HIPB) to eligible retirees and long term disability (LTD) participants. The HIPB is intended to help offset the cost of medical and dental insurance provided by an ASRS employer or the ASRS.

Eligible retirees and LTD participants may receive the HIPB through the six-month reimbursement process under the following conditions. The member:

- Is currently receiving a pension or LTD benefit from the ASRS; **AND**
- Has at least five years of credited ASRS service; **AND**
- Has medical and/or dental coverage as a policy holder through an ASRS employer's *active employee* group plan; **OR**
- Has medical and/or dental coverage as a dependent through an ASRS employer's *active employee* group plan; **AND**
- Retired or became disabled before August 2, 2012; **OR**
- Retired or became disabled on or after August 2, 2012, *and* the group plan is *not* subsidized[*] by the employer; **AND**
- Has out-of-pocket expenses for medical and/or dental premiums.

IMPORTANT NOTES:

Do not use this form for retirees or LTD participants who have medical and/or dental coverage through an ASRS employer's *retiree group* plan or COBRA. Employers must utilize the *Health Insurance Premium Benefit Authorization* form to process the premium benefit for retirees and LTD participants who have coverage through a plan offered to all of the employer's retirees.

Vision, life insurance, disability, or any insurance other than medical and dental is **not** eligible for the HIPB.

SECTION 1 – Retired/LTD Participant Member Information - Completed by retiree/LTD participant eligible for reimbursement.

- Provide your Social Security number, full legal name, mailing address, phone number, and date of birth.

SECTION 2 – Retired/LTD Participant Member Status Information - Completed by retiree/LTD participant eligible for reimbursement.

- Check the appropriate box indicating your ASRS status (Retiree or LTD participant). If LTD participant, indicate Medicare eligibility. **Note:** If your retirement/disability date is on or after August 2, 2012, you may not be eligible for reimbursement. The employer representative should contact the ASRS with questions using Secure Messaging.
- Check the appropriate box indicating your status with this employer.

SECTION 3 – Insurance Coverage Information - Completed by Employer Representative.

- Provide the name, Social Security number, date of birth, and coverage effective date of the policy holder and all dependents.

SECTION 4 – Reimbursement Totals for the Six-Month Period – Completed by Employer Representative.

- Provide the premium amounts per month for medical and/or dental coverage and the member's out-of-pocket expenses (payroll deductions) per month for each premium. List each month separately.

SECTION 5 – Employer Representative Information – Completed and signed by Employer Representative.

Additional Instructions

- Reimbursements are for six-month periods only (January through June **OR** July though December).
- Claims for reimbursement must be submitted for each six-month period and within 60 days **after** the six-month period ends.
- Reimbursement will be the lesser of either the eligible premium benefit amount or the out-of-pocket expenses.
- Reimbursements are paid directly to the retired member or LTD participant.
- Claims for reimbursement will be processed within 60 days of receipt of this form.

Employer Representative, submit the form to the ASRS by creating a Secure Message:

Secure Messaging:
Log into your secure employer account at www.azasrs.gov. Click Secure Messages from the left navigation menu.
Create a new message thread, enter a subject and body text, then attach the form to the message and send it.

[*] An employer-subsidized plan means a portion of the total premiums is paid by the employer, but does not necessarily mean a plan in which the employer uses blended rates to determine the total premium. (A.R.S. §38-783, Laws 2012, Chapter 362 (HB2745))

ARIZONA STATE RETIREMENT SYSTEM (ASRS)
REIMBURSEMENT OF MEDICAL AND/OR DENTAL COST (SIX-MONTH REIMBURSEMENT PROGRAM)

COMPLETE AND SEND TO THE ASRS VIA EMPLOYER SECURE MESSAGING
www.azasrs.gov

Disclosure of member's Social Security number is mandated by Section 6109 of the IRC. The ASRS will use Social Security numbers only to obtain information about an individual's ASRS account and to inform the IRS of distributions and withholdings with respect to the individual's account.

SECTION 1 – Retired/LTD Participant Member Information – TO BE COMPLETED BY THE MEMBER

Social Security Number	Member Name (Last)	(First)	(Middle Initial)

Mailing Address (Street)	Daytime Phone Number

City	State	ZIP	Date of Birth (MM/DD/YYYY)

SECTION 2 – Retired/LTD Participant Member Status Information – TO BE COMPLETED BY THE MEMBER

A. Indicate member status with the ASRS (check ☑ only one):

☐ Arizona State Retirement System retiree

☐ Long Term Disability Plan participant

(Medicare Eligible? ☐ Yes ☐ No)

NOTE: If the retirement/LTD date is on or after August 2, 2012, you may not be eligible for reimbursement. Please see instructions.

B. Indicate member status with the employer (check ☑ only one):

☐ Return to work retiree on active employee group plan

☐ Long Term Disability participant on active employee group plan

☐ Dependent on active employee group plan

SECTION 3 – Insurance Coverage Information – TO BE COMPLETED BY THE EMPLOYER

	Last Name	First Name	Social Security Number	Birth Date (MM/DD/YYYY)	Effective Date of Coverage
Policy Holder					
Dependent					
Dependent					
Dependent					

SECTION 4 – Six-Month Reimbursement Totals (Jan. to June OR July to Dec.) – TO BE COMPLETED BY THE EMPLOYER

Date (List each MM/YYYY)	Total Medical Plan Premium Per Month	Total Dental Plan Premium Per Month	Employee Out-of-Pocket* Medical Premium Per Month	Employee Out-of-Pocket* Dental Premium Per Month	Total Employee Monthly Out-of-Pocket*Premium Per Month
					$ 0.00
					$ 0.00
					$ 0.00
					$ 0.00
					$ 0.00
					$ 0.00
***Out-of-Pocket Premium means payroll deductions per month.**				**Total**	$ 0.00

SECTION 5 – Employer Representative Information – TO BE COMPLETED BY THE EMPLOYER

Name of ASRS Employer	Phone Number	Email Address

☐ By checking this box, I certify that I am the employer representative named below and the information on this form is current and correct. I also understand that typing my name in the Electronic Signature field is the legally binding equivalent to my handwritten signature.

Date

HI Premium Benefit Specialist Electronic Signature