STRS OHIO HealthCare PROGRAM

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www.strsoh.org

RETIREE VERIFICATION OF EMPLOYMENT AND EMPLOYER HEALTH CARE ACCESS

STRS Ohio requires non-Medicare retirees enrolled in an STRS Ohio medical plan to verify their employment status and access to employer medical coverage annually. Coverage under the STRS Ohio Health Care Program is limited for non-Medicare enrollees employed in public and private positions. Employed enrollees are eligible only for ***secondary*** medical and prescription drug coverage through STRS Ohio's Basic Plan if they: (1) are eligible for medical and prescription drug coverage through their employer, or (2) hold a position for which other similarly situated employees are eligible for medical and prescription drug coverage at the same cost as full-time employees. The rule applies to all employed enrollees who are not eligible for Medicare, regardless of hire date or type of employment.

You can submit the information through your Online Personal Account or complete this form and return it by mail or fax it to 614-233-8713. Failure to provide verification may result in the termination of your STRS Ohio medical and prescription drug coverage. Further information is available in the *Employment After Retirement* brochure, available at www.strsoh.org. If you have questions, please contact STRS Ohio.

SECTION 1 — Check the box that applies to your employment status as an STRS Ohio retiree.

Are you employed? ❑ Yes ❑ No *If yes, proceed to Section 2. If no, proceed to Section 3.*

SECTION 2 — Provide the information requested below.

Employer name *(print)* _____ Phone _____

Employer address _____
Street City State ZIP code

Title of position held by STRS Ohio retiree _____

Please answer the questions below regarding the medical and prescription drug coverage available through your employer.

A. Is medical *and* prescription drug coverage available to you or to employees in similarly situated positions? ❑ **Yes** ❑ **No**

B. Is the coverage and cost equivalent to what is offered to full-time employees at this employer? ❑ **Yes** ❑ **No**
*If you answered **no to either A or B**, stop here and proceed to Section 3.*
*If you answered **yes to A and B**, you are not eligible for primary coverage through STRS Ohio. Please complete the remainder of this section as well as Section 3.*

C. What is your employment start date? _____

D. What is your coverage effective date through your employer? _____

Review the following important information.

- STRS Ohio coverage for you and any covered dependents will terminate the first of the month following notification of access to employer medical and prescription drug coverage. To apply for secondary coverage through STRS Ohio, please contact STRS Ohio.
- Premium refunds for retroactive STRS Ohio coverage will not be issued.
- Proceed to Section 3.

SECTION 3 — Read, complete and sign.

I hereby attest the information I have provided is complete and truthful. I understand any false or incomplete information I provide to STRS Ohio, or failure to complete this form, could result in the termination of my STRS Ohio medical and prescription drug coverage, loss of coverage and repayment of medical premium subsidy and claim costs STRS Ohio has paid on my behalf. 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. By signing below, I acknowledge if I become employed at a later date or if my employment status changes, I will immediately inform STRS Ohio. If my employment status changes in the future, I may be eligible to enroll in an STRS Ohio medical plan with primary coverage; however, I acknowledge it will be my responsibility to contact STRS Ohio regarding enrollment and eligibility rules.

Benefit recipient's name *(print)* _____ STRS Ohio account no. _____
or
Address _____ Social Security no. _____
Street City State ZIP code

Phone _____ Email _____

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