NOTICE OF CHANGE IN EMPLOYER HEALTH CARE COVERAGE: OPERS BENEFIT RECIPIENT

Ohio Public Employees Retirement System
277 East Town Street, Columbus, Ohio 43215-4642
Employer Outreach: 1-888-400-0965
www.opers.org

A public employer is required to provide health care coverage to re-employed benefit recipients (other than independent contractors) if it is provided to other employees in comparable positions or performing comparable work. If available, this coverage cannot be waived unless the benefit recipient has coverage comparable to the employer's coverage under a plan not offered by the employer, Medicare or OPERS.

The employer's coverage is typically the re-employed benefit recipient's primary health care coverage. If the individual is covered by both the public employer and OPERS' health care coverage while re-employed, OPERS' coverage is secondary coverage and shall pay only those health care claims not paid or available under the employer's coverage.

A re-employed retiree is not eligible for OPERS health care coverage while re-employed if he or she fails to enroll in coverage offered by the public employer. If the public employer's coverage is a high deductible health plan, federal law prohibits OPERS' coverage from coordinating with it.

The employer must notify OPERS, in writing, if the re-employed benefit recipient is no longer eligible, or becomes eligible, for the employer's health care coverage. Please include the date the coverage became available or is no longer available.

The OPERS HRA and the OPERS RMA prohibit re-employed retirees (other than independent contractors) from being eligible for a monthly HRA allowance or reimbursement of any medical expenses incurred by the retiree or his/her dependents during the re-employment period. As stated above, if a re-employed retiree (other than an independent contractor) receives such allowance or reimbursements, the retiree may be liable to OPERS and/or the applicable plan.

STEP 1: Benefit Recipient's Personal Information

Social Security Number

Date of Birth

First Name

MI

Last Name

Address

City

State

ZIP Code

STEP 2: Employer Certification of Change of Health Care Coverage

Please complete one of the following sections below:

☐ The re-employed benefit recipient listed on this form will become eligible for coverage.

When will this change first become effective?

☐☐/☐☐/☐☐☐☐

Is this coverage a High Deductible Health Plan?

◯ **Yes** ◯ **No**

OR

☐ The re-employed benefit recipient listed on this form will no longer be eligible for coverage.

When will this change first become effective?

☐☐/☐☐/☐☐☐☐

STEP 3: Employer Certification

Employer

Employer Code

☐☐☐☐ — ☐☐

Address

City State ZIP Code

Signature of Authorized Signer _____ Today's Date ___/___/___

Do not print or type name

Authorized Signer First Name MI Last Name

Title

Work Phone Number

☐☐☐ — ☐☐☐ — ☐☐☐☐

Employer Code

☐☐☐☐ — ☐☐