Ohio Police & Fire Pension Fund
140 East Town Street
Columbus, OH 43215
Phone: 1-888-864-8363
Fax: (614) 628–1777
www.op–f.org

HEALTH CARE STIPEND ELIGIBILITY FORM

Complete and return this form to the Ohio Police & Fire Pension Fund (OP&F) if you are planning to retire or are a service retiree, disability benefit recipient, or a surviving spouse and would like to participate in OP&F's health care stipend program. You may also use this form to waive eligibility for the stipend program. If you waive eligibility, there are limited opportunities to become eligible in the future.

The information provided will help determine if you and/or your dependents are eligible to receive a Health Reimbursement Arrangement (HRA) funded by a stipend from OP&F. To receive the stipend, you must enroll in an eligible health care or prescription drug plan within 60 days after you terminate service from your OP&F employer or experience another Qualifying Life Event (QLE). These QLEs are listed in Section B of this form. Employer plans (other than the member's COBRA plan) or other group plans are not eligible.

If this form is not received within 60 days of the qualifying event, your request for eligibility will be denied.

In the event you are not eligible for a stipend or waive your eligibility, you may still have access to the services of the Alight Retiree Health Solutions. Please call to speak with an Alight benefit advisor at 1-844-290-3674, Monday-Friday, from 8 a.m.-9 p.m.

Section A: Member information

Name: First, MI, Last, suffix (Jr. III, etc.)

❑ Male ❑ Police
❑ Female ❑ Fire

Social Security Number

Street Address / Post office box

Home telephone

Date of birth

City, State, ZIP code

Alternate telephone

Medicare number (if applicable)

Email

Marital status ❑ Single ❑ Married ❑ Divorced ❑ Married, but previously divorced

If married, spouse's name (first, middle initial, last)

Marriage date(s)

Divorce date(s)

(continue to Section B on next page)

Section B: Eligibility for stipend

OP&F will determine eligibility to receive a stipend in the form of an annual contribution to a HRA. To become eligible, you must have a QLE and enroll in a health plan and/or prescription drug plan within 60 days after the QLE. If you or your dependents have access to any other group coverage, including employer or retirement coverage, you are not eligible for the OP&F health care stipend. If you are not yet receiving an OP&F pension benefit, complete this form with the employment status and any health insurance you are eligible for after retirement.

Qualifying Life Event: If you are a new retiree, or if you were not eligible for the OP&F stipend in the past, or if you were previously ineligible for access to OP&F's health care stipend, you may become eligible if you have experienced a QLE. Review the QLE selections below, mark the appropriate box, and provide the corresponding proof along with this application.

List the effective date of your QLE and check the appropriate box below: ☐☐/☐☐/☐☐☐☐ **(mm/dd/yyyy)**

- ☐ **Involuntary loss of group health care coverage,** including loss of coverage from your employer when you retire from an OP&F-covered position. Include proof of loss of coverage with this form, along with the names of those who have lost coverage. Also send proof of new coverage if it is obtained outside of Alight/eHealth, (such as Healthcare.gov) with the effective date and names of those being covered within 60 days of QLE;
- ☐ **Enrollment into COBRA** due to member's loss of coverage from their employer. Provide proof of loss of employer coverage with names of those who lost coverage and proof of enrollment into COBRA plan;
- ☐ **Change in family status** (i.e., birth, adoption, marriage, divorce). Provide proof of this change (birth or marriage certificate, adoption papers, and divorce decree);
- ☐ **Medicare eligibility**. Provide a copy of the Medicare card. " If you are currently enrolled and receiving a stipend you *do not* need to complete this form. Only complete if you are using your Medicare enrollment as a QLE;
- ☐ **Termination of COBRA**.
- ☐ **Other:** _____

Section C: Dependent information

List dependents to enroll in or terminate from OP&F's health care stipend. You must attach a copy of all supporting documentation such as birth certificate, marriage certificate, Medicare or Medicaid card and return it to OP&F. Listing a dependent does not automatically entitle them to eligibility.

Dependent's name	Social Security number	Date of birth	Gender	Relationship	Eligibility status
1			☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Other:_____	☐ Eligible for Medicare* ☐ Eligible for Medicaid* ☐ Disabled/incapacitated
For the person listed as dependent 1, it is my intent to (*check one*): ☐ Enroll and participate in OP&F's retiree health care stipend ☐ Terminate participation in OP&F's retiree health care stipend					
2			☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Other:_____	☐ Eligible for Medicare* ☐ Eligible for Medicaid* ☐ Disabled/incapacitated
For the person listed as dependent 2, it is my intent to (*check one*): ☐ Enroll and participate in OP&F's retiree health care stipend ☐ Terminate participation in OP&F's retiree health care stipend					
3			☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Other:_____	☐ Eligible for Medicare* ☐ Eligible for Medicaid* ☐ Disabled/incapacitated
For the person listed as dependent 3, it is my intent to (*check one*): ☐ Enroll and participate in OP&F's retiree health care stipend ☐ Terminate participation in OP&F's retiree health care stipend					
4			☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Other:_____	☐ Eligible for Medicare* ☐ Eligible for Medicaid* ☐ Disabled/incapacitated
For the person listed as dependent 4, it is my intent to (*check one*): ☐ Enroll and participate in OP&F's retiree health care stipend ☐ Terminate participation in OP&F's retiree health care stipend					

***If enrolled, you must attach a copy of the dependent's Medicare or Medicaid card.**

Section D: Access to other health care

If you or your dependents are eligible for any other group coverage, including employer or retirement coverage, that person will not be eligible for an OP&F health care stipend. If you are not yet receiving an OP&F pension benefit, fill out this form using the employment status and health insurance you have access to after retirement.

OP&F member:

❑ Yes ❑ No Are you currently employed?
If yes, name of your employer: _____

❑ Yes ❑ No Are you currently receiving retirement benefits from another retirement system?
If yes, name of the other retirement system(s) or program (s): _____

❑ Yes ❑ No Are you eligible for health care coverage sponsored by an employer or another retirement system?
If yes, what are the effective dates of coverage: _____
If yes, types of coverage offered: ❑ medical ❑ prescription ❑ dental ❑ vision

❑ Yes ❑ No Are you eligible for early Medicare?

Spouse:

❑ Yes ❑ No Is your spouse currently employed?
If yes, name of spouse's employer: _____

❑ Yes ❑ No Is your spouse currently receiving retirement benefits from another retirement system?
If yes, name of the other retirement system(s) or program (s): _____

❑ Yes ❑ No Is your spouse eligible for health care coverage sponsored by an employer or retirement system?
If yes, what are the effective dates of coverage: _____
If yes, types of coverage offered: ❑ medical ❑ prescription ❑ dental ❑ vision

❑ Yes ❑ No Is your spouse eligible for early Medicare?

Dependent children (from Section C):

❑ Yes ❑ No Are any of your dependents currently employed? If yes...
... dependent's name: _____; name of the employer: _____
... dependent's name: _____; name of the employer: _____
... dependent's name: _____; name of the employer: _____

❑ Yes ❑ No Are any of your dependents currently receiving retirement benefits from another retirement system? If yes...
... dependent's name: _____; name of the retirement system(s) or program(s): _____
... dependent's name: _____; name of the retirement system(s) or program(s): _____
... dependent's name: _____; name of the retirement system(s) or program(s): _____

❑ Yes ❑ No Are any of your dependents eligible for health care coverage from an employer or retirement system? If yes...
...dependent's name: _____; what are the effective dates of coverage: _____
If yes, types of coverage offered: ❑ medical ❑ prescription ❑ dental ❑ vision
...dependent's name: _____; what are the effective dates of coverage: _____
If yes, types of coverage offered: ❑ medical ❑ prescription ❑ dental ❑ vision
...dependent's name: _____; what are the effective dates of coverage: _____
If yes, types of coverage offered: ❑ medical ❑ prescription ❑ dental ❑ vision

❑ Yes ❑ No Are any of your dependents eligible for early Medicare? If yes...
...name(s) of these dependents: _____
_____
_____

Section E: Member signature and acknowledgement

I, the member described in Section A of this *Health Care Stipend Eligibility Form,* certify that all statements made and information provided on this form is true and correct. I understand that completing this form does not guarantee eligibility for OP&F's health care stipend.

I further certify that my dependents are eligible to participate in OP&F's health care stipend program. I acknowledge that it is my responsibility to notify OP&F within 30 days of a dependent becoming ineligible for the stipend. I authorize OP&F to recover any reimbursements received by me as a result of false or inaccurate information. I further understand and acknowledge that OP&F has the right to independently verify any information or statement made by me on this form.

I acknowledge that, when eligible, I am required to enroll in Medicare Parts A and B and that I must maintain my eligibility to continue to be eligible for the OP&F stipend. I will notify OP&F immediately if I become eligible for Medicare Part A or Part B, and I will be responsible for all overpaid stipends resulting from my failure to notify OP&F. Once participation has been waived, I acknowledge there are limited opportunities to re-enroll in OP&F's health care stipend.

I acknowledge there is no promise, guarantee, contract or vested right to access to health care coverage or a stipend allowance. The OP&F Board of Trustees has the discretion to review, rescind, modify or change the health care stipend at any time.

❑ **YES**, I want to become eligible for OP&F's health care stipend.

IF YOU CHECKED YES ABOVE: You acknowledge that if you are not yet eligible for Medicare, you will be enrolling in a major medical health care plan in compliance with the Affordable Care Act and that this plan is not a group plan or a plan available from either your employer or your spouse's employer. The stipend you may be eligible for may only be used for individual and family plans available either on the open marketplace or through the Alight Retiree Health Solutions. If the OP&F health care stipend is used for an ineligible plan, your access to the stipend may be terminated.

If you enroll in a plan on the open marketplace, you must provide proof of enrollment and names of those enrolled.

By signing below, you are agreeing to the above conditions and that all information provided on this form is factual.

❑ **No**, I do not want to participate in OP&F's health care stipend program. I have read the "Eligibility for Stipend" section of this form (Section B) and understand my future eligibility for a stipend.

Member's Signature: ▶	Date of signature:

Section F: Notary public requirement

The notary public in good standing must sign in the space provided in this section and affix their seal.

State of _____, County of _____, ss:

The foregoing *Health Care Stipend Eligibility Form* was acknowledged before me by the person named in the foregoing Section A, this _____ day of _____ , 20_____.

Affix Seal here	Notary's signature: ▶
	Print name:
	My commission expires: