

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 Aon/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;
- Proof of loss of eligibility in CHIP/Children's Medicaid Program**. Provide a copy of the notification with effective date of loss.

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			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	<input type="checkbox"/> Eligible for Medicare* <input type="checkbox"/> Eligible for Medicaid* <input type="checkbox"/> Disabled/incapacitated
For the person listed as dependent 1 above, it is my intent to (<i>check one</i>): <input type="checkbox"/> Enroll and participate in OP&F's retiree health care stipend <input type="checkbox"/> Terminate participation in OP&F's retiree health care stipend					
2			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	<input type="checkbox"/> Eligible for Medicare* <input type="checkbox"/> Eligible for Medicaid* <input type="checkbox"/> Disabled/incapacitated
For the person listed as dependent 2 above, it is my intent to (<i>check one</i>): <input type="checkbox"/> Enroll and participate in OP&F's retiree health care stipend <input type="checkbox"/> Terminate participation in OP&F's retiree health care stipend					
3			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	<input type="checkbox"/> Eligible for Medicare* <input type="checkbox"/> Eligible for Medicaid* <input type="checkbox"/> Disabled/incapacitated
For the person listed as dependent 3 above, it is my intent to (<i>check one</i>): <input type="checkbox"/> Enroll and participate in OP&F's retiree health care stipend <input type="checkbox"/> Terminate participation in OP&F's retiree health care stipend					
4			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	<input type="checkbox"/> Eligible for Medicare* <input type="checkbox"/> Eligible for Medicaid* <input type="checkbox"/> Disabled/incapacitated
For the person listed as dependent 4 above, it is my intent to (<i>check one</i>): <input type="checkbox"/> Enroll and participate in OP&F's retiree health care stipend <input type="checkbox"/> 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 Aon Retiree Health Exchange. 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.

Check and initial where indicated if you agree to the above conditions: _____ (initials)

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: