City of Bristol Virginia  
300 Lee Street  
Bristol, VA 24201  
Finance Department  
1-276-821-6090

### QUARTERLY - RETIREE STATEMENT OF INSURANCE COVERAGE

**PART 1: INFORMATION**

<table>
<thead>
<tr>
<th>TODAYS DATE:</th>
<th>City Retiree</th>
<th>School Retiree</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF RETIREE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADDRESS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CITY, STATE, ZIP:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHONE #:</td>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>SOCIAL SECURITY # (last 4 digits): XXX - XX -</td>
<td>Date of Birth:</td>
<td></td>
</tr>
</tbody>
</table>

**PART 2: POLICY & PAYMENT VERIFICATION - QUARTERLY**

<table>
<thead>
<tr>
<th>The Quarter you are reporting: (Check One)</th>
<th>January - March</th>
<th>April - June</th>
<th>July - September</th>
<th>October - December</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year:</td>
<td>Year:</td>
<td>Year:</td>
<td>Year:</td>
<td></td>
</tr>
</tbody>
</table>

**DEADLINE to submit to the City Finance Department:**

- April 15th
- July 15th
- October 15th
- January 15th

No eligible retiree shall be paid more than the actual monthly cost of their health insurance (out-of-pocket). This benefit shall end on the date of an eligible retiree’s qualification for Medicare eligibility (by age or disability) or his or her death, whichever shall first occur.

**Proof of Payment:**

| Total Premium paid. This amount is on the direct deposit or receipt. |
| Month/Year | Month/Year | Month/Year |
| $ | $ | $ |

**Spouses portion:**

| $ | $ | $ |

**Retiree’s portion:**

| $ | $ | $ |

**NOTE:**

Failure to provide proof of insurance and payments will result in suspension of the monthly premium health benefit until proof can be provided.

**Part 3: Medicare Eligible**

Medicare Eligible is defined as supplement(s) Part A, B or D are offered either by reaching 65 years of age or Under 65 years of age and eligible by reason of disability.

- If you are Medicare eligible please check the box, provide eligibility date, sign bottom of the form and submit back to our office.
- If you are NOT Medicare Eligible, please check the box and complete Parts 2 & 3.

I am Medicare Eligible: [ ]  
I am NOT Medicare Eligible: [ ]  
Date of Eligibility: Turn 65 or Medicare Disability

**PART 4: RETIREE SIGNATURE**

I certify the information I have provided on this document is true.
I understand any willful falsification of facts presented may result in prosecution as provided by law.
I understand I am required to report any changes at the time of the change.
I understand if information is not provided by the due date, I will lose the benefit until the information is provided.
I understand if I am Medicare Eligible, my benefit ceases.
This benefit shall not be paid to any eligible retiree unless the retiree provides to the city proof of payment of their health insurance premium.

Signature: [ ]  
Date: [ ]  

Created: 6/4/2018