ORANGE COUNTY OPEB HEALTH INSURANCE SUBSIDY FORM

Name:_____ Retiree ID #:_____

Address:_____ Phone #:_____

City, State ZIP:_____ FRS Retirement Date:_____

I am retired from Orange County Government and receiving a Health Insurance Subsidy from Florida Retirement System. I understand that I am eligible to receive a Health Insurance Subsidy from Orange County based on my combined years of service under one or more participating agencies of Orange County. The amount to be paid per month is established by the Orange County OPEB Section 115 Trust Agreement. I understand that it is my responsibility to notify Human Resources upon a change in my address or phone number. I also understand I will be responsible for repaying Orange County in the event of an overpayment of Health Insurance Subsidy benefits.

_____ _____

Retiree Signature Date

HR DEPARTMENT USE ONLY

❑ Enrollment ❑ Retro Request ❑ Deceased (date) _____

❑ Address/Phone Change ❑ Name Change

I. YEARS OF SERVICE CALCULATION

OFFICE	Dates of Eligible Service		Years of Service
	From	To	
BCC			
		Total Eligible Service Years	

II. SUBSIDY CALCULATION

Total number of eligible service years from Section I, above:	Total Subsidy
_____ x $ 3.00 per year _____ x $5.00 per year (min $75) - IAFF ILOD	$

❑ FRS Subsidy Verified ❑ W-9 Attached ❑ Direct Deposit Form Attached

❑ Proof of FRS Retro Attached

_____ _____

HR Preparer Date

PAYROLL DEPARTMENT USE ONLY

III. RETRO SUBSIDY PAYMENT CALCULATION:

Eligible months: _____	Total Retro Subsidy
Retro eligible _____ month(s) x total from Section II, above	$

_____ _____

Payroll Preparer Date