



SCHOOL EMPLOYEES RETIREMENT SYSTEM OF OHIO

300 E. BROAD ST., SUITE 100 • COLUMBUS, OHIO 43215-3746

614-222-5853 • Toll-Free 800-878-5853 • www.ohsers.org

2018 HEALTH CARE PREMIUM DISCOUNT APPLICATION

To qualify, one family member enrolled in SERS health care coverage must be eligible for Medicare.

Individuals and families with lower incomes can save 25% on their SERS health care premiums through the Health Care Premium Discount Program. (Discount does not apply to dental and vision premiums.)

You need to be at or below the qualifying income for your household size to receive the premium discount.

SERS determines eligibility by:

- 1) Adding together your and your spouse's incomes from 2016
- 2) Subtracting the SERS health care premiums you and your family members will pay in 2018
- 3) Subtracting the Medicare Part B reimbursement you will be eligible to receive in 2018.

Household Size	Qualifying Income
1	\$15,075
2	\$20,300
3	\$25,525
4	\$30,750
5	\$35,975
6	\$41,200
7	\$46,425
8	\$51,650

If you think you might qualify, please submit an application. SERS will do the math and let you know.

Premium reductions are approved for a calendar year. A new application is required each year.

SECTION 1: Personal Information (Please Print)		
BENEFIT RECIPIENT'S NAME		SOCIAL SECURITY NUMBER <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
HOME TELEPHONE NUMBER ()		DATE OF BIRTH
STREET ADDRESS OR ROUTE NUMBER OR P.O. BOX		
CITY	STATE	ZIP CODE
SPOUSE'S NAME		
SOCIAL SECURITY NUMBER <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		DATE OF BIRTH
DEPENDENTS IN THE SECTION BELOW, LIST YOUR CHILDREN AND ANY OTHER PERSON LISTED ON YOUR 2016 FEDERAL INCOME TAX RETURN. <i>For anyone not on SERS' health care coverage, please attach a copy of your federal tax form as proof.</i>		
NAME		NAME
SOCIAL SECURITY NUMBER <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		SOCIAL SECURITY NUMBER <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
DATE OF BIRTH		DATE OF BIRTH
If you have more than two dependents, attach a separate page with their names, SSNs, and dates of birth.		

OVER

SECTION 2: Gross Household Income for 2016

Income	Is income per month or per year?	Benefit Recipient	Is income per month or per year?	Spouse, if applicable
SERS Pension	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$
Social Security	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$
Additional Pensions	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$
Alimony	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$
Annuities Taxable Amount	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$
Child Support	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$
Income from an Estate	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$
Interest Income	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$
IRA Distribution Taxable Amount	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$
Public Assistance (welfare check)	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$
Supplemental Security Income (SSI)	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$
Income from a Trust	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$
Unemployment benefits	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$
Veterans Benefits	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$
Wages	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$
Workers Compensation	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$	<input type="checkbox"/> MONTH <input type="checkbox"/> YEAR	\$

SECTION 3: 2017 Income Changes

Fill out this section if there has been a major change in your household finances during the past year. For example, if your income changed because your spouse died, please explain how your income was affected and the date of the change. This information will be considered in determining your eligibility.

SECTION 4: Acknowledgement

The information provided on this application is true and accurate. I understand that any false or inaccurate information can result in revocation of the premium subsidy and recovery by SERS of any subsidy amounts.

Benefit Recipient Signature or Power of Attorney

Date

RETURN TO:

School Employees Retirement System of Ohio, 300 E. Broad St., Suite 100, Columbus, Ohio 43215-3746