Insurance Carrier Certification of Group Insurance Policy

Purpose of the Form

- Use this form to certify eligibility of a group insurance policy for payment of retirees' premiums by PERSI.

Instructions

1. Complete the form in blue or black ink.
2. Complete the **Insurance Carrier Information**. If your payment mailing address is a P.O. Box, provide a street address in the **Physical Location Address** section for delivery of payments by courier or other package delivery service (for use when urgent delivery is necessary).
3. Read the **Terms of Agreement between Insurance Carrier and PERSI** and place a checkmark in the box for each item.
4. Have an officer of the company or corporation complete the **Certification of Insurance Carrier**.
5. Return this form and attachments to PERSI.

Plan Information

Plan Name	Policy Number

Insurance Carrier Information

Carrier Name			Federal EIN
Payment Mailing Address	**Street or P.O. Box**		
	City	**State**	**Zip Code**
Physical Location Address	**Street or P.O. Box**		
	City	**State**	**Zip Code**
Daytime Phone Number (include area code)		**Fax Number** (include area code)	
Contact Name – First, Middle, Last			**Contact Email Address**

Terms of Agreement between Insurance Carrier and PERSI

- ☐ The Insurance Carrier certifies that all premiums are qualified group health, dental, vision, long-term care, prescription drug or life insurance premiums.
- ☐ The Insurance Carrier will accept one payment for premiums of multiple retirees accompanied by an itemized report showing name, policy number and payment amount for each retiree.
- ☐ PERSI's only responsibility regarding this insurance agreement is to deduct and remit the premium payments as directed by the insured member.
- ☐ The Insurance Carrier agrees to promptly notify PERSI of any changes in the applicable premiums—including, but not limited to, termination of the policy—and agrees to promptly return any overpayments to PERSI.

Certification of Insurance Carrier

I certify that I am an officer of the above named insurance carrier authorized to bind the company or corporation in this matter and hereby agree to abide by the terms of agreement stated above:

Name of Authorized Officer – First, Middle, Last	Position Title
Signature	**Date – mm/dd/yyyy**

Public Employee Retirement System of Idaho
P. O. Box 83720, Boise, ID 83720-0078
1-800-451-8228 • 208-334-3365 • Fax 208-334-3805
www.persi.idaho.gov • frontdesk@persi.idaho.gov