



Prince William County Retiree Health Insurance Credit Plan

Request for Health Insurance Credit - Update

Return completed forms:

- 1) via email: PWCCredit@boltonusa.com
- 2) via secure upload: <https://www.boltonusa.com/prince-william-county-retired-employees/>
- 3) or via regular mail: Prince William County c/o Bolton
1 W. Pennsylvania Avenue Suite 600
Towson, MD 21204

Retiree Information (please print legibly)			
1. Name (First)	(MI)	(Last)	(Jr./Sr.)
2. Address (Street)		(City)	(State) (Zip)
3. Daytime Phone Number ()			
4. How do you prefer to be contacted? <input type="checkbox"/> Mail <input type="checkbox"/> Email		5. Email Address	
6. Check the appropriate box: <input type="checkbox"/> I am a VRS retiree. <input type="checkbox"/> I am receiving a disability pension from VRS. <input type="checkbox"/> I am a Supplemental Retirement Plan retiree.		7. Reason for request: <input type="checkbox"/> Change in insurance premiums or policy <input type="checkbox"/> Annual Update	8. Are you covered by a Medicare Part B policy? <input type="checkbox"/> Yes (if yes, list effective date and premium) Effective Date: _____ Monthly Premium: \$ _____ <input type="checkbox"/> No
<input type="checkbox"/> There are no changes to my Insurance Policy Information (please sign and date form)			
Medical Insurance Policy Information			
9. Provider Name		10. Monthly Premium Amount	
11. Does this policy cover other family members? <input type="checkbox"/> Yes (if yes, what portion of the premium is for your coverage only?): \$ _____ <input type="checkbox"/> No		12. Effective Date of Premium	
Dental Insurance Policy Information			
13. Provider Name		14. Monthly Premium Amount	
15. Does this policy cover other family members? <input type="checkbox"/> Yes (if yes, what portion of the premium is for your coverage only?): \$ _____ <input type="checkbox"/> No		16. Effective Date of Premium	
Additional Insurance Policy Information (examples – vision, supplemental, Medicare Part D, etc.)			
17. Provider Name		18. Monthly Premium Amount	
19. Does this policy cover other family members? <input type="checkbox"/> Yes (if yes, what portion of the premium is for your coverage only?): \$ _____ <input type="checkbox"/> No		20. Effective Date of Premium	
Retiree Certification			
I certify the information I have provided on this document is true, and I understand that any willful falsification of facts presented may result in prosecution for a Class I misdemeanor as provided by law.			
<input type="checkbox"/> By checking this box, I certify that the typed name below serves as my electronic signature.			
_____ Retiree Signature			_____ Date