THE PENSION RESOURCE CENTER, LLC
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Miami Spring Police & Fire Retirement System
Health Insurance Premium Withholding Form

Participant Information:

Name: _____Social Security # _____
Address: _____
City, State, Zip:_____ Gender: M/F_____
Date of Birth: _____Retirement/Termination Date: _____

I am receiving a normal retirement (separated from service after attainment of normal retirement age) or disability retirement under the Plan. ____Yes ____No
(If yes, continue to complete form. If no, you are not eligible for this benefit.)

I am receiving an early retirement under the Plan. ____ Yes _____No
(If yes, you are not eligible for this benefit. If no, continue to complete form.)

Health Insurance Provider Information

Insurance Company Name:_____
Group Number (if applicable):_____ Policy Number:_____
Monthly Premium Amount:_____ or One Time Premium Disbursement: _____

Insurance Type (please check one)	**Coverage Type (please check one)**
__ Medical __ Dental **__ Vision** **__ LTC (long term care)**	**__ Single __ Family**

Payment Remittance Address: _____
City, State, Zip:_____

Withholding Authorization and Signature

1. I hereby authorize the Retirement Plan to deduct the monthly premium amount set forth above from my monthly pension annuity. This will result in a decrease of my monthly pension annuity. By signing this form I acknowledge that I have been advised that the Pension Board reserves the right to impose an administrative charge as may be necessary to offset the cost of this program.
2. I understand it is my responsibility, as the participant, to inform the Retirement Plan of any change related to my health insurance premium deduction including, but not limited to, coverage, insurance company, or premium changes. I freely accept this obligation to notify the Pension Board.
3. I understand that the Retirement Plan is not responsible for lapsed premiums or lapsed

insurance policy coverage or any other coverage or benefit issues that may arise between my insurance carrier and myself.

4. I take full responsibility for the accuracy and truth of all the information I have provided and certify that I am entitled to these benefits.
5. I understand that by electing to participate in the federal tax exclusion, I will be decreasing my federal taxable income. This tax exclusion may not apply to state taxation.
6. I understand that I may not request additional tax-preferred treatment of the applicable exclusion amount (up to $3,000.00 annually), from any other qualified retirement plans (i.e. Governmental defined benefit plans, 457 plans, or 403(b) plans).
7 I understand that the Retirement System is complying with federal law by withholding insurance premiums from my pension benefits. In doing so, the Retirement System is only performing an administrative function and is only responsible for payment of premiums, as required by law.
8. I understand that the health insurance premium withholding may affect tax withholding from my monthly pension annuity.

Signed:_____Date:_____

IMPORTANT LEGAL NOTICE

THE IRS HAS PROVIDED ONLY LIMITED GUIDANCE TO DATE ON THE APPLICATION OF THIS PROGRAM. AS A CONDITION OF PARTICIPATION IN THIS PROGRAM, THE MEMBER ACCEPTS ALL RESPONSIBILITY FOR TRUTH OF THE INFORMATION PROVIDED TO THE PLAN. IN ADDITION, IN CONSIDERATION OF PARTICIPATION, THE MEMBER AGREES THAT THE RETIREMENT FUND, ITS STAFF OR ADVISORS, AND THE EMPLOYER HAVE NO LIABILITY FOR ANY ADDITIONAL TAX LIABILITY, INCLUDING INTEREST AND PENALTIES THAT MAY ARISE FROM PARTICIPATION.

AS THIS WAIVER INVOLVES YOUR LEGAL RIGHTS, YOU ARE ADVISED TO SEEK COMPETENT LEGAL ADVICE PRIOR TO PARTICIPATING IN THE PROGRAM.

I UNDERSTAND AND AGREE THAT I HAVE HAD A FULL OPPORTUNITY TO HAVE MY QUESTIONS ANSWERED AND TO SEEK OUTSIDE ADVICE.

_____

Name of Participant **Date**

WAIVER OF CLAIMS

BY SIGNING THIS FORM, I AGREE THAT I WILL NOT MAKE ANY LEGAL CLAIM OF ANY KIND AGAINST THE RETIREMENT SYSTEM, ITS STAFF AND ADVISORS, AND THE EMPLOYER SHOULD MY PARTICIPATION IN THIS PROGRAM RESULT IN UNEXPECTED TAX LIABILITY TO ME, INCLUDING INTEREST AND PENALTIES. I UNDERSTAND THAT MY ABILITY TO PARTICIPATE IN THIS PROGRAM IS A VALUABLE BENEFIT FOR WHICH I AM WILLING TO SIGN THIS WAIVER OF ALL CLAIMS. I FURTHER RELEASE THE RETIREMENT SYSTEM, ITS STAFF AND ADVISORS, AND THE EMPLOYER FROM ANY LIABILITY ARISING FROM THE ADMINISTRATION OF PAYMENTS TO ANY INSURER.

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Signature of Participant **Date**