

**CITY OF OKEECHOBEE
MUNICIPAL FIREFIGHTERS' PENSION FUND**

AUTHORIZATION FOR DEDUCTION FROM RETIREMENT BENEFITS

WHEREAS, Section 175.061(7), Florida Statutes, provides that the Board of Trustees may, upon written request by the retiree of the plan, withhold from the monthly retirement payment those funds that are necessary to pay for benefits received through the governmental entity from which the employee retired or to pay for accident, health and long term care insurance from an insurance carrier not associated with the governmental entity from which the employee retired; and;

WHEREAS, Section 408 of the Internal Revenue Code was amended by the Pension Protection Act of 2006 to provide that "eligible retired public safety officers" will receive up to a \$3,000 taxable income exclusion toward the cost of accident, health or long-term care insurance if payment of the premiums is made directly to the provider of the accident, health or long-term care insurance plan by deduction from a distribution from the eligible retirement plan;

1. Therefore, I, the undersigned retired firefighter of the City of Okeechobee do hereby authorize the Board of Trustees of the City of Okeechobee Municipal Firefighters' Pension Trust Fund and the custodian of the Fund to deduct from my monthly pension benefits from the City of Okeechobee Municipal Firefighters' Pension Trust Fund and to pay directly to either (initial one):

_____ A. the City of Okeechobee, and in turn to the provider of accident, health or long-term care insurance, if applicable, those premiums necessary for the undersigned to maintain coverage with the health, accident, or long-term care insurance provided by the City of Okeechobee to retired firefighters and their spouses and dependents, which coverage I have elected to maintain. This authorization shall include any increases in the premiums for such insurance which I have elected to maintain coverage, or

_____ B. my insurance carrier, _____,
Company Name

_____ Company Address for Payments
policy number _____ with a current monthly premium of \$ _____
representing the premium necessary for the undersigned to maintain coverage for the health, accident, or long-term care insurance provided by the named company to me and my spouse and/or dependents, which coverage I have elected to maintain. This authorization shall include any increases in the premiums for such insurance which I have elected to maintain coverage.

2. I hereby certify that I am a retired public safety officer as defined by 42 U.S.C. 3796b(9)(A), that I retired from the plan under Normal Retirement (Not Early) or Disability Retirement and I am not receiving a benefit as a terminated vested person.
3. This deduction shall take effect as soon as is administratively possible after directions are received by the Custodian for the Plan from the Board of Trustees, unless a later start date is directed.
4. This deduction shall continue to be in effect until I request that the Custodian for the Plan be given direction from the Board to cease this deduction, unless a later stop date is directed. The custodian shall cease the deduction as soon as is administratively possible.

5. I understand that:

- A. Every effort will be made to maximize a retiree's annual tax free deductions under this program. However, due to rounding or changing of premiums, differences in alignment between calendar years, taxable years, benefit years and fiscal years, differences between the record keeping and invoicing procedures between the parties involved and due to other administrative matters beyond the control of the parties, neither the Board nor the City makes any guarantee that a retiree will receive the maximum tax free allowance for each benefit year.
- B. This program is subject to change at any time based on Internal Revenue Service interpretations, changes to the PPA, or in the case that this program is found to be in conflict with other federal, state or local laws. In the event of a conflict between this program and governmental regulations, official interpretations, or other relevant legal decisions, this program shall be subordinate.
- C. This program is furnished by the Board of Trustees of the City of Okeechobee Municipal Firefighters' Pension Trust Fund as a customer service to retired participants. Neither the Board nor the City of Okeechobee accepts any liability and makes no guarantees regarding the tax implications of any health insurance premiums paid through this program. As always, retirees should consult with a professional tax advisor regarding matters of the taxability or non-taxability of pension and health insurance benefits.
- D. The Board of Trustees reserves the right to require retirees participating under this program to pay any such costs as may be assessed by the fund custodian, the plan administrator or the qualified health insurance provider in the future for the processing, disbursement or acceptance of insurance policy premium payments.
- E. I understand that the Retirement System 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.
- F. 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.
- G. 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.
- H. 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 systems (i.e. Governmental defined benefit plans, or 403(b) plans).
- I. 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.
- J. I understand that the health insurance premium withholding may affect tax withholding from my monthly pension annuity.

- K. AS A CONDITION OF PARTICIPATION IN THIS PROGRAM, I ACCEPT ALL RESPONSIBILITY FOR TRUTH OF THE INFORMATION PROVIDED TO THE PLAN. IN ADDITION, IN CONSIDERATION OF PARTICIPATION, I AGREE THAT THE RETIREMENT SYSTEM, 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 MY LEGAL RIGHTS, I HAVE BEEN 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.

- L. 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.

Dated: _____

Print Name

Signature

STATE OF FLORIDA
COUNTY OF: _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20____, by _____, who is personally known to me or who has produced _____ as identification.

Notary Public

Return to:
City of Okeechobee Municipal Firefighters' Pension Trust Fund
Pension Resource Center
4360 Northlake Blvd., Ste. 206
Palm Beach Gardens, Florida 33410-6264