MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA

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MFPRSI - Election Form for Public Safety Health Insurance Premium Withholding

Program Explanation

The Federal Pension Protection Act of 2006 (PPA) provides that a portion of a retiree's pension distribution ($3000) may be excluded from the retiree's income for federal income tax purposes if certain conditions are met

The PPA and the IRS guidance stipulate that the following conditions apply:

a) The program is limited to retired public safety officers who retired directly from employment (including spouses and children). Term vested retirees and beneficiaries receiving benefits are not eligible for the program.

b) The retiree must have retired at normal retirement age (age 55 or older) or on disability retirement.

c) The insurance premium must be paid directly by the retirement plan on behalf of the individual to the retiree's insurance plan (including the City if it administers the plan.).

For qualified retirees who enroll, MFPRSI will direct payments to the retiree's, spouse's, or children's insurance provider or their City, if the City is collecting the payments.

Participation will continue until the retiree directs MFPRSI in writing to terminate their participation in this program.

To apply for participation, the retiree must provide the information requested on the following pages, sign the document as required, and return it to the retirement system.

The system will initiate the monthly insurance payments on behalf of the retiree.

PLEASE NOTE: YOU MUST INCLUDE A COPY OF YOUR MOST RECENT INVOICE OR PREMIUM STATEMENT FROM YOUR INSURANCE CARRIER, OR OTHER DOCUMENTATION VERIFYING THE CURRENT PREMIUM AMOUNT AND THE INSURANCE CARRIER'S NAME AND ADDRESS.

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Retiree Information

Member _____ Spouse _____

Address _____ Member SSN: XXX-XX-____

City, State, Zip _____ Phone _____

Health Insurance Provider Information - Complete spouse information only if choosing to deduct for spouse whose policy is separate from member's

Insurance Company or City for Member _____

Insurance Company or City for Spouse _____

Policy Number: Member _____ Spouse _____

Monthly Premium: Member $_____ Spouse $_____

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Authorization and Signature

1. I hereby authorize the retirement System (MFPRSI) to deduct the monthly premium amount identified above, from my monthly pension and to pay that amount directly to the insurance company or the City. This will result in a decrease to the amount of my monthly pension paid directly to me each month. (Periodically, this amount may be adjusted as the retirement System is notified of adjustments in the premium amount.)

2. I understand it is my responsibility to inform MFPRSI of any change related to my premium deduction including, but not limited to, coverage, insurance company, or premium changes. I freely accept this obligation to notify MFPRSI.

3. I understand that MFPRSI 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 me or any family member covered by this program.

4. I take full responsibility for the accuracy and truth of all the information I have provided and certify that I am eligible to have the designated insurance premiums excluded from my taxable income.

5. I understand that amounts deducted from my pension for insurance premiums are intended to be exempt from federal and state income taxes, but that the Retirement System makes no warranty with respect to the tax effects of this withholding program.

6. I understand that the maximum amount of insurance premiums excludable from income from all retirement plans is $3,000 per year in total for me and any family members.

7. I understand that the Retirement System is performing only an administrative function permitted by federal law in withholding insurance premiums from my monthly pension checks. I understand that any and all tax implications of my election are my responsibility alone, and I agree that I will make no claim against the Retirement System for consequences of my election.

8. I hereby authorize the retirement system (MFPRSI) and the identified insurance company or City to provide necessary information to each other concerning this program and the insurance account I have identified herein and the establishment of the payments.

Member's Signature **Date**

IMPORTANT LEGAL NOTICE

I ACCEPT ALL RESPONSIBILITY FOR TRUTH OF THE INFORMATION PROVIDED TO MFPRSI. IN ADDITION, IN CONSIDERATION OF MY PARTICIPATION IN THIS WITHHOLDING PROGRAM, I AGREE THAT MFPRSI, ITS STAFF AND ADVISORS HAVE NO LIABILITY FOR ANY ADDITIONAL TAX LIABILITY, INCLUDING INTEREST AND PENALTIES THAT MAY ARISE FROM MY PARTICIPATION.

I UNDERSTAND THAT THIS ELECTION AND WAIVER INVOLVES MY LEGAL RIGHTS, AND THAT I AM ADVISED TO SEEK COMPETENT LEGAL AND TAX 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.

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, ITS ADVISORS, OR MY FORMER 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 AGREE TO THIS WAIVER OF ALL CLAIMS. I FURTHER RELEASE MFPRSI, ITS STAFF, ITS ADVISORS AND MY FORMER EMPLOYER FROM ANY LIABILITY ARISING FROM THE ADMINISTRATION OF PAYMENTS TO ANY INSURER UNDER THIS PROGRAM.

Member's Signature **Date**