Reset Form

Print Form

Oklahoma Firefighters Pension and Retirement System

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HEALTH ELECTION/CHANGE FORM FOR ELIGIBLE RETIRED PUBLIC SAFETY OFFICER

You should submit this form to the System office at least 30 days before you want to: (1) begin having qualified health insurance premiums deducted from your monthly benefit and paid directly to the provider; (2) make a change in your election; or (3) terminate the direct payment.

Name _____

Social Security Number _____

Department Retired From _____

FOR OFFICIAL USE ONLY	
COMPANY CODE	
DATE ENTERED	

Currently deducting insurance premiums from pension check? ☐ Yes ☐ No (check one)

Part I – Benefit Commencement (check one)

☐ New Insurance Deduction ☐ Change Insurance Deduction ☐ Terminate Insurance Deduction

I request that the above election of my qualified health insurance premiums become effective on _____.

Part II – Retiree Health Election (check one)

I hereby elect to have qualified health insurance premiums deducted from my monthly benefit, and paid directly to the provider identified in Part III below. The qualified health insurance premiums are for coverage under:

☐ an accident or health insurance plan; or

☐ a qualified long-term care insurance contract.

Part III – Payment Instructions (please print)

My health insurance/long-term care insurance premiums should be paid as follows:

Name of Insured/
Contract Holder _____ Account #: _____

Name of Provider _____

Address of Provider _____

_____

Name of Contact _____

Contact Telephone _____

Amount To Be Paid From System to Provider on a Monthly Basis $ _____

(SIGNATURE REQUIRED ON PAGE 2)

Part IV – Retiree's Representations and Understandings

I represent and understand that:

A. direct payment toward my qualified health insurance premiums:

1. may only be made from amounts not yet distributed to me from the System;

2. will continue month-to-month and year-to-year until I give the System office at least 30 days advance notice to terminate or change such payment; and

3. will be sent by the System to the provider when the benefit payments are sent;

B. I am responsible for payment of the full amount of my qualified health insurance premiums, and none of the State of Oklahoma, the System, State Street Bank and Trust Company, the State Board, the Executive Director, nor his staff shall be liable if my insurance is cancelled;

C. I am responsible for notifying the System office on a timely basis of any change in the amount of my qualified health insurance premiums to be paid from my monthly benefit from the System;

D. the amount of qualified health insurance premiums deducted from my monthly benefit from the System, and paid directly to the provider, may be excluded from my gross income, up to $3,000 per year;

E. amounts excluded from income as qualified health insurance premiums may not be taken into account in determining my itemized deduction for medical expenses;

F. I may not exclude from my gross income any health insurance premiums paid by me and reimbursed with distributions from the System;

G. the qualified health insurance premiums are for coverage for myself, my spouse, and my dependents;

H. the plan or contract for which such premiums are paid does not have to be sponsored by my former Participating Municipality; and

I. payment for qualified health insurance premiums deducted from my monthly distributions from the System can only be made after December 31, 2006.

Part V – Certification

I certify that:

A. the information provided on this form is correct and I authorize the action necessary to implement the payment described in Part III above;

B. by reason of disability or attainment of normal retirement date or age, I am separated from service as a public safety officer with my Participating Municipality; and

C. I am not entitled to more than one exclusion from my gross income of up to $3,000 per year for direct payment of qualified health insurance premiums, and I have not elected this exclusion from any other plan.

_____ _____

Signature of Retiree Date

_____

Phone Number