

Bismarck Firefighter's Relief Association Pension Fund Public Safety Health Insurance Premium Withholding Form

Participant Information

Name: _____ Social Security # _____

Address: _____

City, State, Zip: _____ Phone #: _____

Health Insurance Provider Information

Insurance Company Name: _____

Mailing Address: _____

City, State, Zip: _____ Phone #: _____

Group / Policy Number: _____

Monthly Premium Amount: One Time Premium Disbursement: \$ _____

Insurance Type: Medical Dental/Vision Long Term Care

Coverage Type: Single Family

Withholding Authorization and Signature

- I hereby authorize the Pension 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.
- I understand it is my responsibility, as the participant, to inform the Pension 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.
- I understand that the Pension 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.
- 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.
- 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.
- 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).

- I understand that the Pension Plan is complying with federal law by withholding insurance premiums from my pension benefits. In doing so, the Pension Plan is only performing an administrative function and is only responsible for payment of premiums, as required by law.
- I understand that the health insurance premium withholding may affect tax withholding from my monthly pension annuity.

Participant Signature _____ **Date** _____

IMPORTANT LEGAL NOTICE

THE IRS HAS NOT PROVIDED 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 PENSION 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.

Participant Signature _____ **Date** _____

WAIVER OF CLAIMS

BY SIGNING THIS FORM, I AGREE THAT I WILL NOT MAKE ANY LEGAL CLAIM OF ANY KIND AGAINST THE PENSION FUND, 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 PARTICPATE 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.

Participant Signature _____ **Date** _____

Bismarck Firefighter's Relief Association

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