

Bismarck Firefighter's Relief Association Public Safety Officer Insurance Carrier Agreement Form

Health Insurance Provider Information

Legal Name of Insurance Carrier: _____

Payment Mailing Address: _____
(Payments are to be Electronic)

Physical Location Address: _____

Phone Number: _____ Fax: _____

Contact Name: _____ E-Mail: _____

Terms of Agreement between Insurance Carrier and Bismarck Firefighter's Relief Association

- This agreement is between the Bismarck Firefighter's Relief Association and the above named insurance carrier.
- Insurance Carrier agrees to participate in the Retired Public Safety Officers' Insurance Payment Program. Under the program, Bismarck Firefighter's Relief Association members who are retired public safety officers may elect to have Bismarck Firefighter's Relief Association deduct their medical, dental, vision, and long term care insurance premiums from their retirement benefit and pay Insurance Carrier directly.
- Insurance Carrier certifies that all premiums are qualified health insurance premiums under Section 845(a)(4)(D) of the Pension Protection Act.
- Insurance Carrier will accept electronic form of payment.
- Insurance Carrier will provide information for electronic form of payment.
- Insurance Carrier will accept one payment for premiums of multiple retirees accompanied by an itemized report showing name, policy number and payment amount for each retiree.
- Bismarck Firefighter's Relief Associations only responsibility under the Program is to deduct and remit the premium payment as directed by the insured member.
- Insurance Carrier agrees to promptly notify Bismarck Firefighter's Relief Association of any changes in the applicable premiums, including but not limited to, termination of the policy, and agrees to promptly return any overpayments to the Bismarck Firefighter's Relief Association.
- Either Insurance Carrier or the Bismarck Firefighter's Relief Association can terminate this agreement by written notice received no less than 45 days in advance of the termination date.

Certification of Insurance Carrier

I certify that I am an officer of the above named insurance carrier authorized to bind the company or corporation in this matter and hereby agree to abide by the terms of agreement stated above.

Name: _____ Title: _____

Signature: _____ Date: _____

Bismarck Firefighter's Relief Association

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