CITY OF LEESBURG MUNICIPAL
FIREFIGHTERS' RETIREMENT PLAN

AUTHORIZATION FOR DEDUCTION FROM RETIREMENT BENEFITS

The purpose of this form is to elect to have qualified health insurance premiums paid directly from your monthly retirement benefit to the City of Leesburg as the provider of your health insurance.

Member Information

Full name_____

Social Security Number_____

Mailing Address_____

_____

Daytime Phone Number_____

Florida Statutes provides that the Board of Trustees may, upon written request by the retiree of the plan, authorize the plan administrator to withhold from that retiree's monthly retirement payment those funds that are necessary to pay for medical benefits received through the governmental entity from which the employee retired;

Retired City of Leesburg Firefighters and their dependents are eligible to participate in the medical insurance program provided by the City of Leesburg upon the retired Firefighters or their eligible dependents paying the appropriate premium; and

Section 402 of the Internal Revenue Code was amended by the Pension Protection Act of 2006, Section 845, to provide beginning January 1, 2007 that "eligible retired public safety officers" may receive up to a $3,000 taxable income exclusion toward the cost of health insurance if payment of the premiums is made directly to the provider of the accident or health insurance plan by deduction from a distribution from the eligible retirement plan;

1. I, the undersigned retired Firefighter of the City of Leesburg do hereby authorize the Board of Trustees of the City of Leesburg Firefighters' Retirement Plan and the custodian of the City of Leesburg Firefighters' Retirement Plan, Salem Trust, to deduct from my monthly pension benefits from the City of Leesburg Firefighters' Retirement Plan and to pay directly to the City of Leesburg, and in turn to the provider of accident or health insurance, if applicable, those premiums necessary for the undersigned to maintain coverage with the life, health, accident, hospitalization or annuity insurance provided by the City of Leesburg 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.

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 after attaining Normal Retirement Age (Not Early) or under a Disability

Retirement and I am not receiving a benefit as a terminated vested person.

3. I understand that the maximum amount of insurance premiums excludable from income from this retirement plan, as well as any other qualified government retirement plan is an aggregate amount of $3000 per year.

4. I understand that any and all tax implications of this election are solely my responsibility and I agree that I will make no claim against the City of Leesburg Firefighters' Retirement Plan for the consequences of my election.

5. This deduction shall take effect as soon as is administratively possible after directions are received by Salem Trust from the Board of Trustees, unless a later start date is directed.

6. This deduction shall continue to be in effect until I request that Salem Trust 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.

7. I understand that:

A. Every effort will be made to maximize a retiree's annual 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 Pension Protection Act, 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. The Board is performing an administrative function as permitted by federal law in withholding insurance premiums from my pension benefits... Neither the Board nor the City of Leesburg 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 me.

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 am responsible for complying with the applicable exclusion amount (up to $3,000.00 annually), from this and 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.

IMPORTANT LEGAL NOTICE

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 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 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.

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 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.

_____ _____
Member Signature **Date**

STATE OF _____ COUNTY OF _____

The foregoing instrument was acknowledged before me by means of:
[ ] physical presence or [ ] online notarization

this _____/_____/_____ by _____, who is personally known to me
(date) (name of person acknowledging)

or who has produced _____as identification and who did (did not) take an oath.
(Type of Identification Produced)

_____
(Signature of Notary Public)

Return To: City of Leesburg Municipal Firemen's Retirement Plan
33937 Tarawood Drive
Leesburg, Florida 34788

*SOCIAL SECURITY NUMBER COLLECTION DISCLOSURE STATEMENT
Your social security number is requested for purposes of determining eligibility for retirement benefits as a plan member, retiree or beneficiary; for processing of retirement benefits; for verification of retirement benefits; for income reporting; or for other notice or disclosures related to retirement benefits. Your social security number will be used solely for one or more of these purposes. The collection and use of your social security number is authorized by Section 119.071(5)(a)(2)(a)(II), Florida Statutes.

Office use only

Updated/Entered By: _____ *Date:* _____