OKLAHOMA LAW ENFORCEMENT RETIREMENT SYSTEM

Health Election/Change Form for Eligible Retired Public Safety Officers^

Applicant Information

Applicant Name _____ Applicant SSN _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email _____

Part I – Benefit Commencement (Check One)

☐ Add Insurance ☐ Change Insurance ☐ Terminate Insurance

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 from the System, 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

My qualified health insurance premiums should be paid as follows:

Name of Insured/
Contract Holder _____ Account #:_____

Name of Provider _____

Address of Provider _____

City_____ State _____ Zip Code _____

Name of Contact _____ Contact Telephone _____

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

^A "public safety officer" is an individual serving a public agency in an official capacity, with or without compensation, as a law enforcement officer, firefighter, chaplain, or as a member of a rescue squad or ambulance crew. An "eligible retired public safety officer" is an individual who, by reason of disability or attainment of normal retirement date, is separated from service as a public safety officer with his or her participating employer.

Applicant Name _____

Part IV – Retiree's Representations and Understandings

I understand that:

A. direct payment toward my qualified health insurance premiums:

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

   b. will continue month-to-month and year-to-year until I give the System office at least 30 days advance notice to terminate such payments; and

   c. will be sent by the System to the provider when the retirement checks 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, The Northern Trust Company, the 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 employer; 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 payments described in Part III above;

B. by reason of disability or attainment of normal retirement date, I am separated from service as a public safety officer with my participating employer (i.e., I served in an official capacity, with or without compensation, as a law enforcement officer, firefighter, chaplain, or as a member of a rescue squad or ambulance crew); 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

The Applicant stated above has attested that he/she has read this form, knows the contents thereof, and that the information contained therein are true and correct.

Date _____ _____

Applicant's Signature

Submission Information

Completed form can be sent to OLERS via:

Mail: 421 N.W. 13th, Suite 100, Oklahoma City, OK 73103
Fax: (405) 522-5004
Email: forms@olers.ok.gov