OKLAHOMA POLICE PENSION AND RETIREMENT SYSTEM
1001 N.W. 63rd Street, Suite 305
Oklahoma City, Oklahoma 73116-7335
Tel: (405) 840-3555 or (800) 347-6552 Fax: (405) 840-8465
www.opprs.ok.gov

HEALTH ELECTION/CHANGE FORM

Please submit this form to the Oklahoma Police Pension and Retirement System ("System") 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.

Participant Name	Participant SSN
Mailing Address	Member Name/SSN (if not Participant)
City, State, Zip Code	City of Membership
Telephone	Email

Part I – Deduction Election/Commencement *(check one)*

☐ Add Deduction ☐ Change Deduction ☐ Terminate Deduction

I request that the above election to add/change/terminate qualified health insurance premium deductions from my monthly benefit take effect on the last business day of _____ (month/year).

Part II – Participant Health Insurance Type *(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 IV 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 – Participant Understanding

I 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 or my insurance provider/administrator** give the System at least 30 days advance notice to change or terminate such payment; and

3. will be sent by the System to the provider when the pension payments are deposited (end of each month);

B. I am solely responsible for payment of the full amount of my qualified health insurance premiums. The State of Oklahoma, System, Oklahoma Police Pension and Retirement Board, Executive Director, nor the staff shall be held liable if my insurance is cancelled;

C. 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, **for eligible retired public safety officers only**, in accordance with Section 402(l) of the Internal Revenue Code of 1986, as amended;

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

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

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

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

Part IV – Payment Instructions ***(please list multiple deductions (amounts and types) separately)***

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

Name of Insured/Policy Holder: Tulsa FOP 93 Health and Welfare Trust

Type(s) of Coverage: _____

Name of Provider: Rooney Insurance Agency

Provider Mailing Address: 4700 South Garnett Road, Ste #200

Tulsa, OK 74146

Provider Contact Information: Jo McDaniel (918) 878-3425

Monthly Amount(s) to be Paid Toward My Premium(s) $ _____

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 IV 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 Participant Date

D. As the Participant's insurance provider/administrator, I certify that the information provided on this form is correct and I authorize the action necessary to implement the payment described in Part IV above on behalf of the Participant.

_____ _____

Signature of Insurance Provider/Administrator (if applicable) Date