



AUTHORIZATION FOR INSURANCE PREMIUM DEDUCTION

State Form 54969 (R / 3-13)

INDIANA PUBLIC RETIREMENT SYSTEM 1977 POLICE OFFICERS' & FIREFIGHTERS' PENSION & DISABILITY FUND

1 North Capitol Avenue, Suite 011
Indianapolis, IN 46204-2014
Telephone: (888) 526-1687 (Toll-free)
Fax: (866) 591-9441 (Toll-free)
E-mail: questions@inprs.in.gov
Web site: www.inprs.in.gov

*This agency is requesting disclosure of Social Security numbers in accordance with Internal Revenue Code 3405; disclosure is mandatory and this form cannot be processed without it.

INSTRUCTIONS

1. Remove the instruction pages included with this form prior to returning the completed form to the Indiana Public Retirement System (INPRS) at the address shown above.
2. Type or print using black ink. Complete all information and place the Member's name, Social Security number and Pension ID number at the top of each page as requested.
3. This completed form may be delivered to the lobby of INPRS at the address indicated on the form. Lobby hours are 8 a.m. to 5 p.m. on weekdays. The agency is closed on weekends and holidays, including all State-designated holidays.
4. Questions or changes? Call customer service, toll-free, at (888) 526-1687, Monday – Friday, 8 a.m.- 8 p.m. EST.

ABOUT THE AUTHORIZATION FOR INSURANCE PREMIUM DEDUCTION

Important Legal Notice

This is a benefit enacted by Congress in 2006. INPRS is proceeding with implementation of the program based on its understanding of the information currently available from the IRS, with the anticipation that the program might require revisions and adjustments as the provisions of the Pension Protection Act are interpreted and clarified. By participating in the program, you acknowledge that changes may be required and that changes could affect your eligibility or the eligibility of your insurance carrier or policy. It may also result in reversal of some transactions. You agree that any benefit or privilege granted under this program is subject to change or revocation, that you will cooperate with any adjustments and that INPRS is not responsible for any consequence of any change to the program, including unexpected tax liability, interest and penalties.

Waiver of Claims

By signing this form, I agree that I will not make any legal claim of any kind against INPRS, its staff and advisors 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 agree to this waiver of all claims. I further release INPRS, its staff and advisors from any liability arising from the administration of payments to any insurer.

Eligibility for Tax-free Distributions for Health and Long Term Care Instructions

- Public Safety Officer means an individual serving a public agency in an official capacity, with or without compensation, as a law enforcement officer, as a firefighter, as a chaplain for a police or fire department, or as a member of a rescue squad or ambulance crew.
- Eligible Retired Public Safety Officer (including police, corrections, probation, parole and judicial officers), means an individual who, by reason of disability or attainment of normal retirement age, is separated from service as a public safety officer with the employer who maintains the eligible retirement plan from which distributions are made.
- Normal retirement age for determination of eligibility means a member who has retired with an unreduced benefit.

Insurance Carrier Agreement Information

- You must submit a separate copy of the *Insurance Carrier Agreement* (State Form 55017) for each insurance policy you are designating for direct payment by INPRS.
- The insurance premiums designated will be paid directly to the insurance company or to employers who have self-insured plans by INPRS and the payment will be deducted from your monthly benefit.
- You can use income from more than one retirement plan to pay insurance premiums, but the maximum income exclusion the IRS allows for all plans combined is \$3,000 per year. You are responsible for complying with this federal limit and for the consequences if your designated insurance premiums exceed the limit.
- Premium payments will begin the first month after INPRS receives a completed and signed form. Incomplete and unsigned forms will not be processed and you will be notified that you must resubmit the form.

RETIRED MEMBER INFORMATION

Retired member's name		Social Security number <i>(last 4 digits)*</i>	Pension ID (PID) number
Address	Telephone number with area code	Other telephone number with area code	
City	State	ZIP Code	E-mail address

RETIRED MEMBER REQUESTED ACTION

(Select one) New designation Change to previously designated policy Stop previously designated payments

Retired member's name	Social Security number (last 4 digits)*	Pension ID (PID) number
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INSURANCE CARRIER INFORMATION			
Insurance carrier name			Group/policy number
Address	Telephone number with area code	Other telephone number with area code	
City	State	ZIP Code	E-mail address
Insurance types (Select all that apply) <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Long term care			Premium amount \$

EMPLOYER INFORMATION			
Employer name			Submission unit number
Address	Telephone number with area code	Other telephone number with area code	
City	State	ZIP Code	E-mail address

EMPLOYER REQUESTED ACTION			
<input type="checkbox"/> Insurance carrier change			
Current carrier		New carrier	
Premium amount to be deducted \$			As of date (mm/dd/yyyy)
<input type="checkbox"/> Deduction withholding change			
Current carrier		New deduction amount \$	As of date (mm/dd/yyyy)

AUTHORIZED AGENT AFFIDAVIT		
As authorized agent for the employer that administers the above named insurance plan, I certify that this individual is a covered participant in the _____ employer insurance plan. Name of insurance plan		
Authorized agent's signature (Controller, clerk-treasurer, or trustee)	Authorized agent's name (printed)	Date (mm/dd/yyyy)

RETIRED MEMBER ACKNOWLEDGEMENT	
1. I hereby authorize INPRS to deduct the monthly insurance premium amount set forth above directly from my monthly pension benefit. I understand that this will result in a decrease in my monthly benefit payment. 2. I understand it is my responsibility, as the participant, to inform INPRS 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 INPRS. 3. I understand it is my responsibility, as the participant, to inform the insurance vendor 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 insurance vendor. 4. I understand that INPRS 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. 5. I certify that I am eligible to have the designated insurance premiums excluded from taxable income. 6. I understand the maximum amount of insurance premiums excludible from income from all retirement plans is \$3000 per year. 7. I take full responsibility for the accuracy and truth of all information I have provided and certify I am entitled to these benefits. 8. I understand that I may not request additional tax-preferred treatment of the applicable exclusion amount (up to \$3,000 annually), from any other qualified retirement plans (i.e., Governmental defined benefit plans, 457 plans or 403(b) plans). 9. I understand that INPRS is complying with federal law by withholding insurance premiums from my pension benefits. In doing so, INPRS is only performing an administrative function and is only responsible for payment of premiums, as required by law. 10. I understand that any and all tax implications of my election are my responsibility alone and I agree that I will make no claim against INPRS for consequences of my election.	
I have read and I understand the information in this form and its instructions and agree to all the conditions for this election, including the Waiver of Claims (on page 1).	
Retired member's signature	Date (mm/dd/yyyy)

Retired member's name	Social Security number (last 4 digits)*	Pension ID (PID) number
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FREQUENTLY ASKED QUESTIONS (FAQS) FOR ELIGIBLE RETIRED PUBLIC SAFETY OFFICERS

(This FAQ applies only to members of the 1977 Fund.)

Q1: What does this benefit provide?

A: The HELPS Retirees provision of the Pension Protection Act (PPA) of 2006 allows eligible retired public safety officers to use up to \$3,000 per year from their qualified government retirement plan, on a tax-excluded basis, to pay for health insurance or long-term care insurance premiums. In order for you to get the tax-excluded benefit, the money must be paid directly from your pension fund to a health or long-term care insurance company. Further, in order to receive the tax exclusion, you must claim it as a deduction on your IRS Form 1040, as explained in the Form 1040 instructions.

Q2: Who is an eligible retired public safety officer for purposes of the exclusion?

A: Eligible retired public safety officers include those who have separated from service with their INPRS-covered employer due to disability or after reaching normal retirement age. A public safety officer who retires before reaching normal retirement age is not an eligible retired public safety officer, unless the public safety officer retires by reason of disability. In addition, survivors are not eligible to make this election.

Q3: OK, I know that I'm an eligible retired public safety officer. What do I need to do to get this benefit?

A: Contact INPRS at (888) 526-1687 and ask about the \$3,000 tax-excluded benefit for purchasing health insurance or long-term care insurance under the 1977 Fund. The election form is available online at www.INPRS.in.gov. You must submit your election form to the 1977 Fund by December 1 of each year.

Q4: What happens if both my spouse and I are eligible retired public safety officers?

A: Both you and your spouse would be eligible to use up to \$3,000 each on a tax-excluded basis to purchase health insurance or long-term care insurance for a total family limit of \$6,000. But the premiums would have to be directly deducted for both you and your spouse.

Q5: Under what circumstances are the provisions of HELPS available for retired public safety officers?

A: The favorable tax treatment is available only when an eligible retired public safety officer chooses to have an amount subtracted from his or her distributions from an Eligible Government Plan and that amount is used to pay qualified health insurance premiums. The employer sponsoring the Eligible Government Plan is not required to offer such an election.

Q6: Are eligible retired public safety officers limited in the amount they can exclude from gross income under the HELPS Retirees provision of the PPA?

A: Yes. The aggregate amount that is permitted to be excluded, for any taxable year, from an eligible retired public safety officer's gross income is limited to \$3,000. For purposes of applying this \$3,000 limitation, distributions with respect to an eligible retired public safety officer that are used to pay for qualified health insurance premiums from all Eligible Government Plans are cumulative.

Q7: Are amounts used to pay qualified health insurance premiums that are excluded from gross income taken into account for purposes of determining the itemized deduction for medical care expenses?

A: No. Amounts used to pay qualified health insurance premiums that are excluded from gross income under 402(I) are not taken into account in determining the itemized deduction for medical care expenses.

Q8: What if the IRS does not agree with my income tax exclusion?

INPRS is released from any unexpected tax liability for the fund member as a result of them making this election.

IC 36-8-8-17.2

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Entry field	Field description
RETIRED MEMBER INFORMATION	
Retired member's name	Enter the complete name of the retired member.
Social Security number	Enter the last 4 digits of the retired member's Social Security number.
Pension ID (PID) number	Enter the retired member's Pension ID (PID) number.
Address, City, State, ZIP Code	Enter the retired member's street or mailing address.
Telephone number/Other telephone number	Enter telephone numbers including area codes for the retired member.
E-mail address	Enter the retired member's e-mail address, if applicable.
RETIRED MEMBER REQUESTED ACTION	
Select one	<ul style="list-style-type: none"> • New designation – You must submit a separate copy of the <i>Insurance Carrier Agreement</i> (State Form 55017) for each insurance policy you are designating for direct payment by INPRS. • Change to previously designated policy - You must submit a separate copy of the <i>Insurance Carrier Agreement</i> (State Form 55017) for each insurance policy you are designating for direct payment by INPRS • Stop previously designated payments – This action ends payment for insurance coverage and therefore, insurance coverage.
INSURANCE CARRIER INFORMATION	
Insurance carrier's name	Enter the complete name of the insurance carrier.
Group/policy number	Enter the complete group insurance or individual policy number.
Address, City, State, ZIP Code	Enter the insurance carrier's street or mailing address.
Telephone number/Other telephone number	Enter telephone numbers including area codes for the insurance carrier.
E-mail address	Enter the insurance carrier e-mail address, if applicable.
EMPLOYER INFORMATION	
Employer's name	Enter the complete name of the employer.
Submission unit number	Enter the submission unit number for the employer.
Address, City, State, ZIP Code	Enter the employer's street or mailing address.
Telephone number/Other telephone number	Enter telephone numbers including area codes for the employer.
E-mail address	Enter the employer's e-mail address, if applicable.
EMPLOYER REQUESTED ACTION	
Insurance carrier change	If this option is selected, complete the items in the following fields.
Current carrier	Enter the name of the current carrier.
New carrier	Enter the name of the new carrier.
Premium amount to be deducted	Enter the premium amount to be deducted from each benefit payment.
As of date	Enter the effective date of this action; format = mm/dd/yyyy.
Deduction withholding change	If this option is chosen, enter the items in the following fields.
Current carrier	Enter the name of the current carrier.
New deduction amount	Enter the amount to be deducted for insurance from each benefit payment.
As of date	Enter the effective date of this action; format = mm/dd/yyyy.
AUTHORIZED AGENT AFFIDAVIT	
Name of insurance plan	Enter the name of the insurance plan. This should be the same as the carrier named earlier on the form.
Authorized agent's signature	The authorized agent must be a controller, clerk-treasurer, or trustee. The authorized agent must sign and date this form.
Authorized agent's name	The authorized agent's printed name must be included
Date	The authorized agent must include the date the form was signed; format = mm/dd/yyyy.
RETIRED MEMBER ACKNOWLEDGEMENT	
Retired member's signature	The retired member must sign and date this section of the form.
Date	The retired member must include the date the form was signed; format = mm/dd/yyyy.

**INSTRUCTIONS FOR
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HELPFUL INFORMATION			
	INPRS/PERF	INTERNAL REVENUE SERVICE	INDIANA DEPARTMENT OF REVENUE
Telephone numbers	(888) 526-1687 Toll-free	(800) 829-1040 Toll-free	(317) 233-4018 Indianapolis local
	(866) 591-9441 Fax Toll-free	(800) 829-4477 TeleTax	(317) 232-2240 Tax questions
		(800) 829-4059 TDD (hearing impaired)	(317) 233-4952 TDD (hearing impaired)
			(317) 233-2329 Fax
Web site	www.inprs.in.gov	www.irs.gov	www.in.gov/dor