Retired Public Safety Officer Insurance Premium Deduction Program

Wis. Stat. § 40.05 (4r)

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Authorization Form Instructions

Wisconsin Retirement System retired public safety officers may elect to have medical, dental, vision and long-term care insurance premiums deducted from their monthly WRS annuity payments and remitted directly to the annuitant's insurance provider. Eligible annuitants may qualify for an income tax exclusion under the federal Pension Protection Act of 2006.

Federal law determines eligibility for this deduction program. The Department of Employee Trust Funds does not determine eligibility. "Public safety officer" is defined in 26 USC 402 (l) (4) (C). Information about the public safety officer tax exclusion and eligibility to participate is available on the Internal Revenue Service's (IRS) web site. The following links, available through the IRS web site, provide the federal regulations (you must scroll through the information on these sites to find the applicable public safety officer sections):

www.law.cornell.edu/uscode/text/26/402
https://codes.findlaw.com/us/title-42-the-public-health-and-welfare/42-usc-sect-3796.html

A public safety officer must have separated from service as a public safety officer by reason of disability or attainment of normal retirement age with the employer who maintains the retirement plan from which the annuity payments are made and premium deductions are taken. Eligible annuitants may claim the tax exclusion on their income tax returns.

A duty disability benefit does not qualify as a disability retirement benefit. If you have a retirement or 40.63 disability benefit in addition to your duty disability benefit, you can request a premium deduction from your retirement or 40.63 disability benefit. See the *Retired Public Safety Officer Frequently Asked Questions* (ET-4119) for more information.

Annuitant Instructions

1. Print your responses clearly and legibly.
2. Submit a separate form for each eligible insurance policy/plan deduction you wish to have made from your monthly annuity payment.
3. Complete all information in the Annuitant Information Section.
4. Sign to acknowledge agreement to the Annuitant Terms and Conditions.
5. Submit *Instructions, Terms & Conditions,* and *Authorization* form (3 pages) to your designated insurance provider for completion of the Insurance Provider Information Section.
6. Incomplete and/or unsigned forms will not be processed, and you will be notified that you must resubmit the form.
7. Make a copy for your records. Request completed copy from insurance provider.

Note: You must resubmit this form to ETF if any changes have occurred to the data you previously submitted. Insurance Provider Information will only need to be completed if the insurance provider information has changed.

Insurance Provider Instructions

1. Print your responses clearly and legibly.
2. Complete all information in the Insurance Provider Information Section.
3. Sign to acknowledge agreement to the Insurance Provider Terms and Conditions.
4. Return completed form to: Department of Employee Trust Funds, PO Box 7931, Madison WI 53707-7931
5. Incomplete and/or unsigned forms will not be processed, and the annuitant will be notified that the designated insurance provider must resubmit the form.
6. Make a copy for your records and provide annuitant a completed copy.

Note: Annuitants must resubmit this form to ETF if any changes have occurred to the data previously submitted on the form. Insurance Provider Information will only need to be completed if the insurance provider information has changed.

Annuitant Terms and Conditions

- I have read and understand the Retired Public Safety Officer Insurance Premium Deduction Program information.
- I understand that any aspect of this program is subject to federal and/or state law changes.
- I certify that I am a retired public safety officer, as defined by federal law.
- I understand these deductions will be paid directly to the insurance provider on the first business day of each month regardless of my individual premium due date and will continue monthly until written notification of cancellation is received by the Department of Employee Trust Funds.
- I understand it is my responsibility to promptly inform ETF of any additions, changes, or cancellations related to my medical, dental, vision, or long-term care insurance premium deductions.
- I understand these deductions cannot exceed my monthly annuity payment after all other deductions are taken, including federal and state income tax withholding, and that they will reduce my net annuity payment.
- I understand any and all tax implications of my election are my responsibility alone, and I agree that I will make no claim against ETF for consequences of my election.
- I understand I am responsible for all premiums due to my insurance provider until my authorization has been approved, completed, and processed by ETF. I further understand I will receive an *Annuity Payment Statement* as notification of the effective date when deductions will begin from my monthly annuity.
- I understand deductions are prospective only, and no refunds or retroactive deductions or adjustments are available.
- I understand ETF is not responsible for late fees, lapsed premiums, lapsed insurance policy coverage, overpayments to my insurance provider, or any other issues that may arise between my provider and myself.
- I understand that my insurance provider is to promptly return any deductions made on my behalf from annuity payments to which I am not entitled, such as payments made after my death. I further acknowledge that I, my heirs, and/or my estate are responsible for repaying any such deductions that are not returned promptly to ETF by my insurance provider.
- I agree that I will not make any claim against ETF, as administrator of this program, or the Wisconsin Retirement System should my participation in this program result in unexpected tax liability for me, including interest and penalties.

Insurance Provider Terms and Conditions

We have read and understand the Retired Public Safety Officer Insurance Premium Deduction Program information.

- We understand an Automated Clearing House (ACH) deposit on behalf of this annuitant will be made to our bank account on the first business day of each month.
- We understand we will receive a monthly electronic report sent to our billing contact email address. This report will reflect all member policy numbers and associated deposits made to our bank account.
- We understand the Department of Employee Trust Funds' only responsibility under the program is to deduct and remit the deduction as authorized by the annuitant.
- We understand ETF is not responsible for late fees, lapsed premiums, lapsed insurance policy coverage, or any other issues that may arise between the annuitant and us.
- We understand we can terminate this agreement by providing written notice to both ETF and the annuitant no less than 45 days in advance of the termination date.
- We understand ETF will notify us of any deposits made on behalf of the annuitant from payments for which the annuitant was not eligible, such as after the annuitant's death. We further agree to promptly return any such deposit to ETF.

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Retiree Information – To be completed by retiree

First name	MI	Last name

Date of birth (MM/DD/YYYY)	Social Security number or ETF ID	Phone ( )

Mailing address	City	State	ZIP code

Country (if not USA)	Email

At time of retirement:

Age: Position title: Employer name:

Action requested

Check one: ☐ add deduction ☐ Change deduction ☐ Stop deduction

Insurance Provider Name

Member/Policy/Subscriber number	Group number

Insurance type: Check one**:** ☐ Medical ☐ Vision ☐ Dental ☐ Long-Term Care	Requested monthly deduction **$**

I certify by signing below that I elect to participate in the Retired Public Safety Officer Insurance Premium Deduction Program, and I agree to the Annuitant Terms and Conditions.

_____ _____

Annuitant signature Date signed (MM/DD/YYYY)

Annuitant: After signing, submit *Instructions, Terms & Conditions,* and *Authorization* (3 pages) to your insurance provider.

Insurance Provider Information – To be completed by insurance provider

Insurance provider name

Payment mailing address	City	State	ZIP code

Correspondence mailing address	City	State	ZIP code

Billing contact name	Billing contact email address	Billing contact phone

Name of financial institution	Transit routing number	Account number

Name of authorized representative (print)	Title

I certify by signing below that I am an officer of the above named insurance provider authorized to bind the company or corporation in this matter and hereby agree to abide by the Insurance Provider Terms and Conditions of the Retired Public Safety Officer Insurance Premium Deduction Program.

_____ _____

Authorized Representative Signature Date signed (MM/DD/YYYY)

Insurance Provider: After signing, submit this form only (*Authorization)* to:
Department of Employee Trust Funds, PO Box 7931, Madison WI 53707-7931.