Nationwide®

Nationwide Retirement Solutions
Election & Authorization for Withdrawal/Employer Certification of Premiums for Health and/or Long-Term Care Insurance

Participant Information

Plan Name: PALM BEACH COUNTY	Plan ID Number: 003808001
Participant Name:	Participant SSN or Account #:
Mailing Address:	Date of Birth:
City, State, & Zip Code:	Phone Number:
Email Address:	
How would you like to be contacted if additional information is required? ☐ Telephone ☐ Email	

Certification as to Public Safety Officers Status

I am an Eligible Retired Public Safety Officer of the PALM BEACH COUNTY (Enter Plan Name). I am entitled pursuant to Internal Revenue Code Section 402 to elect to have a portion of my accident, qualified health and/or long term care insurance premiums deducted on a pre-tax basis from my Defined Contribution Plan and paid directly to my Insurance Company.

I hereby certify that I am an Eligible Retired Public Safety Officer. I understand that in order to qualify as a Public Safety Officer at the time of retirement, I must have been serving a public agency in an official capacity in one of the categories listed below. I hereby certify that I separated from service with the sponsor of the above plan by reason of disability or retirement and at the time of separation I was serving in an official capacity as **(please check one of the following)**:

☐ An individual involved in crime and juvenile delinquency control or reduction, or enforcement of the criminal laws (including juvenile delinquency), including, but not limited to police, corrections, probation, parole, and judicial officers.

☒ A professional firefighter.

☐ An officially recognized or designated public employee member of a rescue squad or ambulance crew.

☐ An officially recognized or designated member of a legally organized volunteer fire department.

☐ An officially recognized or designated chaplain of a volunteer fire department, fire department, or police department**.**

Insurance Company Information

Name of Insurance Company: Palm Beach County Firefighters Benefits Fund	
Address of Insurance Company: PO Box 20509	
City, State, & Zip Code: West Palm Beach FL, 33416	
Policy or Account Number:	Phone Number of Insurance Company: 561-969-6663
Amount of Withdrawal*:	Due Date of the Premium Payment:
Frequency: ☒ One Time	

*$3,000 annual aggregate maximum

General Certifications

With respect to this election and authorization, I understand and certify the following:

- This election and authorization is only effective up to an annual aggregate maximum of $3,000. This annual maximum applies to a calendar year with respect to distributions from all governmental defined benefit or defined contribution plans, 403(b) plans and 457(b) plans in which I participate. I am responsible for applying this limit.
- Any distributions made pursuant to the Election and Authorization for Withdrawal/Employer Certification Form will apply toward any minimum distributions required pursuant to Internal Revenue Code Section 401(a)(9) for the taxable year.
- This Election and Authorization for Withdrawal/Employer Certification form is not effective until signed by me and certified by the Plan Sponsor.
- If I have requested less than $3,000 on this form, I understand that I must submit an additional Election and Authorization for Withdrawal/Employer Certification form for another premium payment in the current calendar year up to the annual aggregate maximum of $3,000.
- I hereby direct Nationwide Retirement Solutions to make a withdrawal from my Defined Contribution Plan for the purpose of paying up to an annual aggregate maximum of $3,000 for my premiums for coverage under the above policy. Nationwide Retirement Solutions (NRS) will make payment directly to the above insurance company. I further understand that NRS is not permitted to make payment to me or any other person.
- I hereby certify that the accident, health insurance and/or long term care premiums for which I have elected the withdrawal reflected above are qualified health insurance, accident, and/or long term care premiums and therefore will fund only coverage for myself, my spouse and/or my dependents (within the meaning of Internal Revenue Code Section 152).
- I hereby certify that I have not, and will not, request a pre-tax withdrawal of health and/or long term care insurance premiums from any other plan.

I hereby agree to the terms of this Election and Authorization for Withdrawal/Employer Certification form and certify that the information provided above is true, accurate and complete.

Participant Signature:	Date:

Acceptance by the Plan Sponsor (Certification is required at the time of the initial request only)

As an authorized representative of the Plan Sponsor, I certify the following:

- The Participant is a public safety officer as defined above.
- The Participant has separated service.

Date Participant Separated from Service:	
Signature of Plan Sponsor's Authorized Representative:	
Printed Name:	
Title:	Date: