RIVCO 1HR retirement division	**Post-Employment Program Election Form** **LIUNA**

Please complete all pages of this election form and either fax the completed form to (951) 955-8538, email to Retirement@rivco.org, or mail to P.O. Box 1569, Riverside, CA 92502-1569 Attention: Retirement Division. Retain a copy for your records and provide a copy to your Department Human Resources Representative. If you would like to schedule a meeting to review your post-retirement options, please call (951) 955-4981, select Option 2 for the Retirement Division or schedule an appointment online at http://rchr.checkappointments.com/.

Section 1 – Employee Information

☐ LIUNA

Employee ID #	Last Name	First Name	Middle Initial

Social Security Number	Date of Birth	Home Telephone	Alternate Telephone

Home Mailing Address	City	State	Zip Code

Date of Hire	Date of Retirement	Previously Employed with County? (Check one) ☐ No ☐ Yes Dates of Service: From_____ To_____

Personal Email:

Section 2 – Hold Harmless Agreement & Signature

"I hereby become a Participant of the VEBA Health Savings Plan. I realize that the parties involved in this Plan (including, but not limited to the Plan, my employer, my bargaining representative, the Trustees, and the agents of each, collectively referred to as the 'Plan and its agents') cannot guarantee any federal or state tax results or investment results. I acknowledge that any benefits to which I may become entitled are subject to the terms and conditions of the governing Plan documents and applicable law, and that the Plan and its agents may withhold from such benefits (and may transmit to the government) any tax, charge, penalty, assessment, or other amount which is determined to be attributable to or allocable to such benefits or on account of the operations of the Plan and to hold the Plan and its agents harmless with respect to such actions taken in good faith. I understand that my qualifying accrued leave balances will be deposited into the VEBA Health Savings Plan."

_____ _____
Employee Signature Date

Section 3 – VEBA Health Savings Plan Investment Selections

Upon retirement a Health Reimbursement Account will be established for you. As a participant in the VEBA Health Savings Plan, your eligible leave balance accruals will default to the Plan's default investment Nationwide Fixed Account until you make a change to your investment selection. To make investment selection changes log in at healthinvesthra.com and click Investments or call HealthInvest Customer Care Center at (844) 342-5505.

_____ _____
Employee Signature Date

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Section 4 – Deferred Compensation Election

The 2024 maximum allowable contribution to the 457 Deferred Compensation Plan is $23,000 for regular deferrals and $7,500 for Age 50 Catch-up deferrals. If your leave balance exceeds the annual maximum allowable contributions, the amount you elected to defer will be reduced and any remaining balance will be paid to you as cash, and subject to taxes.

(LIUNA) LABORERS' INTERNATIONAL UNION OF NORTH AMERICA
Will you be deferring Compensatory Leave and/or Holiday Leave balances into the 457 Deferred Compensation Plans? ☐ **YES** I would like to defer my Compensatory and/or Holiday leave accruals. ☐ **NO** I understand that if I do not elect to have any Compensatory Leave and/or Holiday Leave deferred into the 457 Deferred Compensation Plan, that I will be taxed on the money that is paid to me and that no changes to this decision will be allowed.
ACCESS TO THE 457(b) DEFERRED COMPENSATION PLAN AFTER SEPARATION
Initial_____ Access to 457(b) Deferred Compensation Plan money is granted 30 days after separation of employment and if retiree has not returned to work for the County of Riverside in any capacity.

Please complete the appropriate box(es) indicating amount to be deducted from final paycheck. I would like my eligible leave accruals deferred in the following manner:

Nationwide	Regular Deferral Amount	50+ Catch-Up Deferral Amount
457 Pre-Tax Contribution:	$	$

corebridge financial	Regular Deferral Amount	50+ Catch-Up Deferral Amount
457 Pre-Tax Contribution:	$	$

I authorize my employer to reduce my salary by the above amount, which will be credited to my Employer's Deferred Compensation Plan. The withholding of my deferred amount by my employer and its payment to the designated investment options will be reflected on my final paycheck. The deferral is to be allocated to the funding options on file with the provider.

Authorized by:

_____ _____

Employee Signature Date

Gallagher | HealthInvest HRA

HI02 5/23 PRC

Automatic Premium Reimbursement

Use this form to set up a recurring reimbursement for your eligible premiums

Set up or change your automatic premium reimbursement online. It's faster and more secure.

(1) Log in at **HRAgo®** (mobile app) or **HealthInvestHRA.com**; (2) Click **Claims**; and (3) Click **Set Up an Automatic Premium Reimbursement**.

Or, mail completed form and supporting documentation to: HealthInvest HRA, PO Box 4390, Clinton, IA 52733-4390.

Claims-eligible participants who are actively-employed and receiving monthly employer contributions must have a minimum account balance of $2,000 to begin/renew an automatic premium reimbursement.

Make sure your documentation has everything we need!

The documentation you submit needs to contain all four of the following:

1. Name of covered individual(s);
2. Coverage period or effective date;
3. Name of insurance carrier; and
4. Premium amount.

Common forms of documentation include your statement of insurance, open enrollment notice, or premium billing statement. **If you are requesting reimbursement for tax-qualified long-term care insurance premiums**, be sure to include a copy of your policy's Declarations page. The Declarations page usually contains confirmation that the policy is tax-qualified.

Is my premium eligible?

The below list of qualified premiums is not a complete list, but it does contain many examples of the types of premiums eligible for reimbursement.

- Medical*
- Dental
- Vision
- Long-term care (tax-qualified; subject to IRS limits)
- Medicare
- Medicare supplement plans
- TRICARE premiums (medical and dental plans)

* *Includes marketplace exchange premiums that **are not or will not be** subsidized by the premium tax credit.*

As a reminder, premiums are not eligible for reimbursement if they are:

1. Paid by an employer;
2. Deducted pre-tax through a Section 125 cafeteria plan;
3. Eligible for pre-tax deduction from your (the participant's) paycheck through your employer's Section 125 cafeteria plan; or
4. Subsidized by the premium tax credit.

What should I do next?

- When your premium amount(s) change or stop, it is your responsibility to notify us to adjust or cancel your automatic premium reimbursement. Failure to update this information may result in your reimbursement(s) being cancelled and/or excess reimbursement amounts being reported as taxable income.
- Be sure to notify us if your direct deposit information or mailing address changes.

Go Green! Sign up for e-communication and avoid the paper clutter.

Make your election online. Log in at **HealthInvestHRA.com** and click **My Profile** to update your **Account Preferences.**

Complete Automatic Premium Reimbursement form on reverse ▶▶

Gallagher | HealthInvest HRA

HI02 5/23 PRC

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1 PARTICIPANT INFORMATION

Clear Form

If you are claims-eligible under more than one participant account, enter the participant account number of the account from which you want your automatic reimbursement. Otherwise, your automatic reimbursement will be taken from the account with the earliest claims-eligibility date. **All information in this section is required to process your automatic premium reimbursement request.**

ACCOUNT NUMBER or SSN _____ DATE OF BIRTH mm / dd / yyyy _____

LAST NAME _____ FIRST NAME _____ M.I. _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

AREA CODE and PHONE NUMBER _____ EMAIL ADDRESS (use home or personal email address) _____

GO GREEN! Sign up for **e-communication** and avoid the paper clutter. Make your election online. Log in at **HealthInvestHRA.com** and click **My Profile** to update your **Account Preferences**..

IMPORTANT: Have you previously separated or retired from the employer that made or is making contributions to this account?

☐ YES
☐ NO

DATE OF SEPARATION or RETIREMENT mm / dd / yyyy _____ EMPLOYER NAME _____

2 CERTIFICATIONS: READ BEFORE SUBMITTING

By completing and submitting this form, you agree to the **Terms and Conditions**, as amended from time to time, which can be found in the **Summary Plan Description**. To get a current copy of the Summary Plan Description, log in at **HealthInvestHRA.com** and click **Resources** or contact our Customer Care Center at 1-844-342-5505.

The following certification applies only to major medical premiums. It does not apply to dental, vision, and tax-qualified long-term care premiums:

- Any major medical premium was **either** (a) for an employer-sponsored group health plan (for coverage provided through an employer) and not for individual market coverage, **or** (2) incurred while you were separated or retired (not employed or re-employed) with the employer that contributed funds to your account.

3 AUTOMATIC PREMIUM REIMBURSEMENT INFORMATION

This is a: ☐ **NEW** request ☐ **CHANGE** to existing reimbursement

Amount of each reimbursement:

NEW AMOUNT $ _____

OLD AMOUNT *(If this is a change)* $ _____

Frequency: ☐ Monthly ☐ Quarterly

BEGIN mm / yyyy: _____

This APR will remain in effect for 12 months or through the end of your current policy period, whichever occurs first. We'll notify you when it's time to renew your APR and submit updated documentation.

Due date of first reimbursement:
(To occur on time, request must be received at least 10 days prior to due date)

☐ 1st or ☐ 15th day of the month

☐ Please make my first reimbursement retroactive to my requested due date, if the due date is in the past, or if this request is not received in time.

Is the policy in your name?

☐ YES
☐ NO

If reimbursement is for a policy not in your name (such as your spouse's), please list his/her name, Social Security number or policy number, and date of birth.

NAME _____ SSN or POLICY NUMBER _____ DATE OF BIRTH _____

4 DIRECT DEPOSIT ENROLLMENT (RECOMMENDED)

Direct deposit is faster and more convenient than waiting to receive paper check reimbursements in the mail. Information you provide below will supersede any previous direct deposit enrollment on file. A voided check is not required.

☐ New request
☐ Use direct deposit already on file

NAME OF BANK OR CREDIT UNION _____ ☐ Checking ☐ Savings

9-DIGIT ROUTING NUMBER (see sample check) _____ ACCOUNT NUMBER (do not include check number) _____