RIVCO 1HR
retirement division

Post-Employment Program Election Form

Management, Confidential, Unrepresented, LEMU, RCDDAA, RSA and RSC

Please complete all pages of this election form and either fax 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 give the original to your Department Human Resources Representative. If you would like to schedule a meeting to review your Post Employment Program options, please call (951) 955-4981, select Option 2 for the Retirement Division or schedule your appointment online at http://rchr.checkappointments.com/.

Section 1 – Employee Information

☐ Management, Confidential, Unrepresented ☐ RCDDAA ☐ LEMU ☐ RSA/RSC

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

Email

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

Section 2 – Post Employment Program Election

Please mark one of the boxes below to reflect the PEP option for which you are selecting to have your eligible leave balances contributed. (Choose one option only):

☐ 100% Special Pay Plan
☐ 100% VEBA Health Savings Plan
☐ 50% VEBA Health Savings Plan and 50% Special Pay Plan

Section 3 – Excess Leave Balances

Will you be deferring excess leave balances into the 457 Deferred Compensation Plans?

The 2023 maximum allowable contribution to the 457 Deferred Compensation Plan is $22,500 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.

☐ YES Please complete the deferred compensation election in this publication.

☐ NO I understand that if I do not elect to have any excess leave balances 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.

_____ Initial Access to 457(b) Deferred Compensation Plan money is granted 30 days after employment and if retiree has not returned to work for the County of Riverside in any capacity.

_____ _____
Employee Signature Date

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Section 4 – VEBA Health Savings Plan Investment Selections

Health Reimbursement Account

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

Section 5 – PEP Investment Selection for the Special Pay Plan

Special Pay Plan Investment Selection

The value of eligible leave balances will be allocated to the funding options on file with the 401(a) Money Purchase Plan provider. My current 401(a) Money Purchase Plan provider is:

☐ Nationwide Retirement Solutions ☐ Corebridge Financial

Access to 401(a) Special Pay 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. Initial Here: _____

I understand that investment returns are subject to market fund performances and are not guaranteed and that I could choose to consult a financial advisor to review my fund selections. I further understand that if I do not make a PEP election, that 100% of my eligible leave balance accruals will be contributed to the Money Purchase Plan Fund allocation on file with the designated vendor.

_____ _____

Employee Signature Date

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Deferred Compensation Election

Would you like to defer your Compensatory Leave and/or your excess leave accruals on final paycheck?

☐ YES I would like my compensatory leave and/or excess leave accruals from PEP deferred.

☐ NO I understand that no changes to this decision will be allowed.

If "Yes", 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

H102 4/19 PRC

Automatic Premium Reimbursement

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

Skip this form! Log in at **healthinvesthra.com** and submit your request online.

Submit paper forms to: claims@healthinvesthra.com | HealthInvest HRA, PO Box 80967, Seattle, WA 98108 | 206-686-1402 fax

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 419 PRC

Automatic Premium Reimbursement

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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** on the menu bar or contact our Customer Care Center at customercare@healthinvesthra.com or 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)

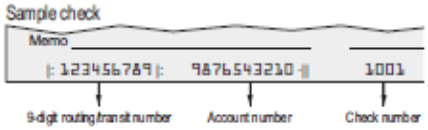
Direct deposit is faster and more convenient than waiting to receive paper check reimbursements in the mail. Information you provide below will supersede any previous direct deposit enrollment on file. A voided check is not required.

☐ 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)



QUESTIONS? 1-844-342-5505 | customercare@healthinvesthra.com | healthinvesthra.com