The following packet of retirement materials contains SBP retirement forms and retiree insurance information. For the TMRS retirement packet go to http://www.tmrs.com/down/forms/TMRS_SRP.pdf For retirement estimates, or to schedule a time to review the retirement paperwork, please contact Rick DeOrdio in Benefits and Employee Wellness. Please do not hesitate to call if you have any questions or need assistance in completing any of the forms.

IRVING
TEXAS

Notice of Retirement

You must return this form to Benefits and Employee Wellness no later than the first day of the month that you plan to retire in with all signatures .

Please type or print clearly.

Name _____

Job Title _____ Department _____

Please consider this my official notice of retirement from the City of Irving. My final day of employment will be _____. I understand that my retirement will be effective the last day of _____.

Comments (optional):

_____

_____

_____

_____

Mailing Address _____ Phone(s) _____

_____

_____

_____

Employee Signature Date

Supervisor Signature Date

Director Signature Date

CITY OF IRVING
Benefits and Employee Wellness
P. O. BOX 152288, IRVING, TX 75015-2288 ◆ 825 W. IRVING BOULEVARD, IRVING, TX 75060
972.721.2696 ◆ Fax 972.721.2582

IRVING
TEXAS

Retirement Checklist

MEMBER INFORMATION

SOCIAL SECURITY NUMBER	MEMBER'S FULL NAME (FIRST, MIDDLE, LAST)		
HOME PHONE NUMBER	MAILING ADDRESS (NUMBER AND STREET)	APT#	
JOB TITLE	CITY	STATE	ZIP CODE
DATE OF BIRTH	DATE OF HIRE	DATE OF RETIREMENT	YEARS OF CREDIBLE SERVICE

HAS A JUDGEMENT BEEN PLACED AGAINST YOUR PENSION PLAN, QUALIFIED DOMESTIC RELATIONS ORDER (QDRO)? ☐ YES ☐ NO

SIGNATURE: _____ DATE:_____

-RETIREES ARE ELIGIBLE TO CONTINUE HEALTH/DENTAL INSURANCE FOR HIMSELF/HERSELF AND ANY DEPENDENTS WHO WERE ALREADY INSURED AT THE TIME OF RETIREMENT. RETIREES CAN CHANGE PLANS ONLY DURING OPEN ENROLLMENT. IF THE RETIREE ELECTS NOT TO CONTINUE COVERAGE, HE/SHE WILL NOT BE ELIGIBLE TO RE-ENROLL AT A LATER DATE.
-RETIREES ARE ALSO ELIGIBLE TO CONTINUE LIFE INSURANCE COVERAGE FOR $15,000 WITH NO AD&D. DEPENDENT COVERAGE IS NOT AVAILABLE TO RETIREES. IF THE RETIREE ELECTS NOT TO CONTINUE LIFE COVERAGE, HE/SHE WILL NOT BE ELIGIBLE TO RE-ENROLL AT A LATER DATE.
-RETIREES WILL MAKE THEIR PREMIUM PAYMENTS PAYABLE TO THE CITY OF IRVING, AND MAIL/DELIVER TO CITY OF IRVING FINANCIAL SERVICES DEPARTMENT, 825 W. IRVING BLVD., IRVING, TEXAS 75060.

HEALTH & LIFE INSURANCE

HEALTH		DENTAL		VISION	LIFE	LEGAL
☐ CHOICE LOCAL PLUS	☐ RET. ONLY	☐ DHMO	☐ RET. ONLY	☐ RET. ONLY	☐ YES	☐ YES
☐ QUALITY OAP	☐ RET. & SPOUSE	☐ DPPO	☐ RET. & FAM.	☐ RET. & SPOUSE	$15,000 POLICY	
☐ QC OAP	☐ RET. & CHILDREN	☐ DPPO	BUY-UP OPTION	☐ RET. & CHILDREN	☐ NO	☐ NO
☐ UHC HMO wRx	☐ RET. & FAMILY			☐ RET. & FAMILY		
☐ UHC Supp. w/ Rx				☐ Buy-Up Option		
☐ WAIVER OF HEALTH COVERAGE		☐ WAIVER OF DENTAL COVERAGE		☐ WAIVER OF VISION COVERAGE	☐ WAIVER OF LIFE COVERAGE	☐ WAIVER OF LEGAL

RETIREE ACKNOWLEDGES BY SIGNATURE BELOW THAT HE/SHE HAS RECEIVED INFORMATION ABOUT THE CITY'S VEBA PLAN AND MEDICAL COVERAGE TO AGE 65, INCLUDING THE REQUIREMENT TO TRANSITION TO MEDICARE OR ANY OTHER MEDICARE TYPE PLANS AT AGE 65.

SIGNATURE FOR BENEFITS: DATE:

_____

TMRS/IFRRF: OPTION: _____

RETIREES WILL NEED TO REVIEW A BENEFIT ESTIMATE PREPARED BY TMRS/IFRRF SHOWING THE MONTHLY BENEFITS RECEIVED IN ORDER TO DECIDE WHICH RETIREMENT OPTION TO SELECT. BENEFIT ESTIMATES MAY BE REQUESTED BY PHONE OR IN WRITING TO TMRS OR IFRRF. TMRS HAS A $7,500 DEATH BENEFIT IN ADDITION TO ANY BENEFITS DUE THE BENEFICIARY THROUGH THE RETIRMENT OPTION SELECTED BY THE RETIREE. TMRS RETIREMENT APPLICATIONS MUST BE SUBMITTED BEFORE THE END OF THE MONTH OF RETIREMENT; RETIREMENT DATE MUST BE THE LAST DAY OF THE MONTH FOR TMRS.

TMRS' EXTRA CREDIT IN MONTHS:

PRIOR SERVICE _____; MILITARY _____; BUY-BACK _____; RESTRICTED PRIOR SERVICE CREDIT_____

SBP: OPTION: _____ LUMP SUM:_____

RETIREES WILL NEED TO REVIEW THE BENEFIT ESTIMATE PREPARED BY THE CITY, WHICH SHOWS THE MONTHLY BENEFITS RECEIVED IN ORDER TO DECIDE WHICH RETIREMENT OPTION TO SELECT. THE RETIREE HAS THE CHOICE OF SELECTING ONE OF SEVERAL OPTIONS OR WITHDRAWING THE DEPOSITS IN A LUMP SUM PAYMENT.

DEFERRED COMPENSATION PLAN: (MASS MUTUAL) ☐ YES ☐ NO

PROVIDE HARTFORD CONTACT INFORMATION. DEPENDING ON AGE, RETIREE HAS THE OPTION TO BEGIN WITHDRAWING FUNDS AT RETIREMENT, OR WAITING UNTIL A LATER DATE TO BEGIN TO RECEIVE BENEFITS FROM THE DEFERRED COMPENSATION PLAN.

REVISED 12/3/15

Drafting Authorization for Retiree Insurance Premiums

Retiree Insurance Elections:

Health	Dental	Vision	Vision–Buy Up	Life	Legal Services
□ Choice Local Plus □ Retiree Only □ Quality OAP □ QC OAP □ Retiree & Spouse □ UHC HMO w/Rx □ Retiree & Children □ UHC Suppl. w/Rx □ Retiree & Family □ Waive coverage Premium:	□ DHMO □ Retiree Only □ DPPO □ Retiree Family □ DPP Buy-Up Option □ Waive coverage Premium:	□ Retiree Only □ Retiree & Spouse □ Retiree & Children □ Retiree & Family □ Waive cov. Premium:	□ Retiree Only □ Retiree & Spouse □ Retiree & Children □ Retiree & Family □ Waive cov. Premium:	□ Yes, $15,000 coverage □ Waive cov. Premium:	□ Yes, Hyatt Legal Plan ❑ Yes, Pre-Paid Legal □ Waive cov. Premium:

I, _____, authorize the City of Irving to draft my checking ____ or savings_____ account at (financial/banking institution name)_____ for my insurance premiums for the benefits noted above on the 10th day of each month, beginning in (month) _____. The purpose of this draft is to pay my monthly insurance premiums. This authorization will remain in effect until I have notified the City of Irving Benefits and Employee Wellness in writing to change or cancel the draft.

Signature: _____ Date: _____

Please attach a voided check

VEBA Eligible	□ Yes	□ No
Premium Amounts Verified	□ Yes	□ No
I Win Credits calculated	□ Yes	□ No
Benefits & Employee Wellness Staff Initials:		

Application for Insurance Premium Deductions for Retired Public Safety Officers & Other Applicable Groups

Effective Date of Retirement_____

I, _____, hereby acknowledge that it was been fully explained to me that my first monthly deduction amount for insurance premium taken from my TMRS/IFRRF monthly benefit check will be for the payment of insurance premiums due for the month of _____ 20___, and that I will need to make payment in the amount of $_____ for _____ 20___, in order to keep my insurance coverage current.

Signature: _____

Date: _____

TMRS HELPS Acknowledgement Form

Life Insurance Beneficiary Designation

Printed Name: _____ Social Security Number: _____

If enrolled in the optional retiree life insurance, please designate your beneficiaries below:

Primary Beneficiaries:		
Name	Social Security #	Date of Birth
Address	City	State
Name	Social Security #	Date of Birth
Address	City	State
Name	Social Security #	Date of Birth
Address	City	State
Contingent Beneficiaries (Optional):		
Name	Social Security #	Date of Birth
Name	Social Security #	Date of Birth
Name	Social Security #	Date of Birth
. **Signature**		**Date**

IRVING
TEXAS

Release of Information to City Departments

Printed Name: _____ Social Security Number: _____

On occasion various city departments request the names and addresses of City of Irving retirees in order to send information about city sponsored events. Please indicate below whether or not Benefits & Employee Wellness has permission to release your name and address to city departments that may request it.

_____ Benefits & Employee Wellness **does** have permission to release my name and address to city departments that request it

_____ Benefits & Employee Wellness **does not** have permission to release my name and address to city departments that request it

Signature: _____ Date: _____

Supplemental Benefit Plan

IRVING TEXAS

Member Retirement Application

SOCIAL SECURITY NUMBER	MEMBER'S FULL NAME (FIRST, MIDDLE, LAST)
HOME PHONE NUMBER	MAILING ADDRESS (NUMBER AND STREET) APT#
JOB TITLE	CITY STATE ZIP CODE
DATE OF BIRTH AGE	DATE OF HIRE DATE OF RETIREMENT YEARS OF CREDIBLE SERVICE POLICE CIVIL SVC?
	☐ YES ☐ NO

SELECTION OF BENEFIT:
INITIAL THE LINE NEXT TO THE BENEFIT YOU WISH TO SELECT.

_______(1) LIFE BENEFIT
_______(2) 5-YEAR CERTAIN/LIFE
_______(3) 10-YEAR CERTAIN/LIFE
_______(4) 15-YEAR CERTAIN/LIFE
_______(5) BENEFICIARY 100% LIFE
_______(6) BENEFICIARY 50% LIFE
_______(7) BENEFICIARY 100% W/ POP-UP
_______(8) BENEFICIARY 50% W/ POP-UP
_______*(9) LUMP SUM PAYMENT (SEE NOTE)

I HEREBY CERTIFY THAT I DO___________ DO NOT____________ HAVE A LAWFUL SPOUSE.

SPOUSAL CONSENT: COMPLETE ONLY IF THE MEMBER HAS A LAWFUL SPOUSE AND SELECTS OPTION (1), (2), (3), (4) OR (9).
I, ____________________________________, THE LAWFUL SPOUSE OF THE ABOVE NAMED MEMBER, UNDERSTAND THAT THE SELECTED OPTION ABOVE IS NOT A JOINT AND SURVIVOR ANNUITY THAT GUARANTEES MONTHLY ANNUITY PAYMENTS PAYABLE FOR MY LIFETIME. I HEREBY CONSENT TO THE RETIREMENT OPTION SELECTED ABOVE BY THE MEMBER.

_______________________________________ _______________________________

SIGNATURE OF SPOUSE DATE

THE STATE OF TEXAS
BEFORE ME, THE UNDERSIGNED AUTHORITY, ON THIS DAY PERSONALLY APPEARED _________________________AND HAVING BEEN DULY SWORN, AFFIRMED THAT STATEMENTS OF FACT MADE IN THE ABOVE AND FOREGOING APPLICATION FOR RETIREMENT BENEFITS ARE TRUE AND CORRECT, AND SIGNED THE SAME IN MY PRESENCE. TO CERTIFY WHICH WITNESS MY HAND AND SEAL OF OFFICE THIS _________________________ DAY OF _____________,
20 ______________.

____

NOTARY PUBLIC

BENEFICIARY (IES)

SOCIAL SECURITY NUMBER FIRST NAME MIDDLE NAME LAST NAME
DATE OF BIRTH SEX ADDRESS (NUMBER AND STREET) APT. NUMBER
RELATIONSHIP (REQUIRED) CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER FIRST NAME MIDDLE NAME LAST NAME
DATE OF BIRTH SEX ADDRESS (NUMBER AND STREET) APT. NUMBER
RELATIONSHIP (REQUIRED) CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER FIRST NAME MIDDLE NAME LAST NAME
DATE OF BIRTH SEX ADDRESS (NUMBER AND STREET) APT. NUMBER
RELATIONSHIP (REQUIRED) CITY STATE ZIP CODE

SIGNATURE OF MEMBER	DATE

BENEFITS & EMPLOYEE WELLNESS USE ONLY

AMOUNT OF BENEFIT PAYABLE PER MONTH (OR 1X LUMP SUM PAYMENT): ___________________________

BENEFIT OPTION SELECTED: ____ EFFECTIVE DATE: ______________________

SR APPROVAL: ______________________________________ DATE:_________________________

*THE GREATER OF THE ACTUARIALLY CALCULATED LUMP SUM PAYMENT OR THE EMPLOYEE'S SBP CONRIBUTIONS WILL BE PAID WHEN THIS OPTION IS SELECTED

CITY OF IRVING SUPPLEMENTAL BENEFIT PLAN

ELECTION OF LUMP-SUM DISTRIBTUION (RETIREMENT BENEFIT)

MEMBER INFORMATION

Member's Name (first,middle,last) _____ Social Security Number _____

Home Mailing Address _____ Daytime Phone Number _____

Mailing address (if different from above) _____ Department Number _____

City _____ State _____ Zip Code _____ Date of Birth _____

I do _____ or do not _____ have a lawful spouse.

I CHOOSE TO HAVE MY REFUND DISTRIBUTED AS FOLLOWS:

(*Please check either Box 1 or Box 2. If checking Box 1, also complete Sections A and B.)*

BOX 1 ☐ DIRECT ROLLOVER

I want the following amount of the taxable portion of my refund transferred to the plan named below, and represent to SBP that it is an eligible plan for the purpose of this transfer. (Note: A Roth IRA, SIMPLE IRA, or Education IRA are not eligible plans.) **I understand that the balance of the taxable portion, if any (less withholding), and the non-taxable portion, will be paid directly to me.**

Part A *Check either "ALL" or write the specific dollar amount (or percentage) you want transferred.*

☐ **ALL** (or) ☐ $ _____ (specific amount) OR Percentage _____ %

Part B (*Name and Address must be completed)*

Name of IRA/Employer Plan _____ Please check one: ☐ IRA ☐ Employer Plan

Address of Eligible Plan _____

City _____ State _____ Zip Code _____

Phone Number of Eligible Plan _____ - _____ - _____ Account # (if applicable) _____

BOX 2 ☐ LUMP SUM PAYMENT

I want the entire refund **(less 20% withholding)** paid directly to me.

Note: The IRS may require you to pay a 10% Excise Tax, in addition to federal income tax, on your refund. You may wish to consult your tax advisor or the IRS to determine your potential liability.

MEMBER CERTIFICATION

Is your separation of employment due to illness or injury? Initial one: YES _____ NO _____

I certify that I have received the printed explanation Special Tax Notice Regarding Plan Payments prior to signing this certification and waive the requirements of 30 days notice by checking one of the boxes above and affirmatively elect to make or not make a direct rollover. I understand federal income tax law requires The City of Irving to withhold 20% income tax on the portion of my refund subject to federal income taxation unless I elect to have the taxable portion transferred directly to an IRA or another eligible employer plan that accepts rollovers. Federal income taxes will be withheld only on the portion of taxable income that is not transferred to another eligible retirement plan. I understand all my deposits will be refunded. **If I initialed "yes" above, I acknowledge that by requesting a refund of my contributions I waive my legal rights to disability retirement benefits.**

_____ _____

Member Signature Date Signed

EMPLOYER CERTIFICATION

I hereby certify that the above named applicant is known to me and that he/she was a participating member of the City of Irving's Supplemental Benefit Plan. I further certify that his/her employment has been terminated and that the last retirement deduction was/will be listed in the Supplemental Benefit Plan report for the pay period ending _____. Our reports indicate that the above named employee has deposits in the SBP as follows:

_____ _____

Title of City Official Date Signed

_____

Signature of City Official

Non-taxable: $ _____ Calculated Benefit

Taxable: $ _____ _____

Total Deposits: $ _____

Last Deposits: $ _____ (for BOT update)

IRVING
TEXAS

Direct Deposit Your Pension Benefit
Supplemental Benefit Plan

Here's How:
1. Complete lines 1 through 4 below.
2. Attach a voided check to this page (NO DEPOSIT SLIPS PLEASE).
3. Read authorization at bottom of form, then sign and date form, approving authorization.
4. Mail this form (with voided check attached below) to:

Bank of Texas, N.A. - Trust Division
Attn: Sam Edwards
5956 Sherry Lane
Suite 1100
Dallas, Texas 75225

Attach a Voided Check Here

1. Type of Authorization ☐ New Application ☐ Change ☐ Cancellation

2. Employee Identification Name _____Social Security #_____

3. Account Identification ☐ Checking ☐ Savings

4. Banking Identification Financial Institution Name_____
Address_____

Authorization

I authorize the Pension Trustee/Agent and the financial institution listed above to electronically deposit my net pay to the account specified each payday. If funds to which I am not entitled are deposited to my account, I authorize my employer to direct the financial institution to return said funds. The authority will remain in effect until I have filed a new authorization at least 30 days in advance of the change.

Signature:_____Date:_____

New 2017 Retiree Group Health Rates
<u>New Retirees</u> – Retired on or after Jan. 1, 2011

These rates are effective January 1, 2017, through December 31, 2017.
Credits will be calculated at the time of retirement – Service based credits, I Win credits

Coverage	Choice Local Plus Monthly Total Cost	Quality Open Access Plus Monthly Total Cost	Quality Connect Open Access Plus Monthly Total Cost
Retiree Only	$1,479.23	$1,352.64	$1,136.82
Retiree/Spouse	$2,403.01	$2,136.14	$1,706.20
Retiree/Children	$2,351.70	$2,092.52	$1,623.09
Retiree/Family	$3,299.42	$2,898.07	$2,164.24

Retiree Health Rates – Age 65 or older
(2017 Plan Year)

These rates are effective January 1, 2017, through December 31, 2017.

United Healthcare PEBA Plans

Senior Supplement w/Rx

Plan A: Plan pays 100%
Part B: Plan pays 100%
Part A : Retiree pays $0
Part D Gap Coverage : Full
Rx Deductible : $0
Premium = $457.56 per retiree

The City reserves the right to revise benefit plan rates in the event of substantial plan cost or benefit change during the plan year.

Retiree Dental and Vision Rates
(2017 Plan Year)

These rates are effective January 1, 2017, through December 31, 2017.

Cigna Dental

Coverage	Monthly Cost Dental HMO	Standard Option Dental PPO Monthly Cost	Buy-Up Option Dental PPO Monthly Cost
Employee Only	$12.42	$36.80	$42.70
Employee/Family	$27.00	$95.84	$111.22

NVA Vision Plan (National Vision Administrators)

Coverage	Monthly Cost	Buy-Up Option
Employee Only	$ 5.02	$ 9.34
Employee/Spouse	$ 7.52	$ 14.00
Employee/Children	$ 8.76	$ 16.30
Employee/Family	$ 12.52	$ 23.30

Life Insurance (CIGNA Life Insurance)

Insurance Amount You Purchase = $15,000
Monthly Premium = $2.55
Annual Premium = $ 30.60

The City reserves the right to revise benefit plan rates in the event of substantial plan cost or benefit change during the plan year.