

Knox County Retirement & Pension Board

City-County Building, Room 371
 400 Main Street
 Knoxville, Tennessee 37902-2409
 Phone: (865) 215-2323 Fax: (865) 215-2421



Medical Expense Retirement Plan Payment Election Form for Retired Participants

Employee # _____

Part 1 EMPLOYEE DATA

| | | | |
|---------------|-------|-----------------------|--------------------|
| Employee Name | | Social Security No. | Date of Birth |
| Street | | Date of Last Paycheck | Date of Retirement |
| City | State | Zip | Daytime Phone |

Check One: County Dept: _____ Schools Dept: _____

Part 2 PAYMENT AUTHORIZATION

Check One:

Use for payment of medical and/or dental insurance premiums (UOPP Retirees not eligible for this option)

Medical Insurance Plan _____ Monthly Premium Amount \$ _____ Effective Date _____

Dental Insurance Plan _____ Monthly Premium Amount \$ _____ Effective Date _____

Please note if you elect to have the premium for county sponsored post retirement health insurance paid from the plan, the full amount of your monthly premiums will be paid in advance on a quarterly basis until such time as the funds in your account are distributed in full or you change your selection.

- Lump Sum Distribution, payable to me. 20% of the taxable portion will be withheld for federal income tax.
- Quarterly payment of \$ _____ (\$250 minimum). Paid each quarter 15 business days after the end of the quarter.
- \$ _____ (specific amount). The final check amount after 20% of the taxable portion is withheld for federal income tax.
- I elect to have the non-taxable amount distributed to me and the taxable amount transferred directly to the IRA or Employer's Plan listed below. (Complete Direct Transfer Information).
- I elect to have the non-taxable amount **and** the taxable amount transferred directly to the IRA or Employer's Plan listed below. (Complete Direct Transfer Information).
- I want \$ _____ or _____% of my distribution transferred directly to the IRA or Employer's Plan listed below and the remainder issued to me. (Complete Direct Transfer Information).

Part 3 PAYMENT OPTIONS FOR PAYMENT TO PARTICIPANT (Direct deposit not available for Direct Transfers at this time)

Please check one:

- I hereby authorize Knox County to direct deposit payment of my Medical Expense Retirement Plan. Please complete the following information or attach a voided check.

| | |
|------------------------------------|--|
| Financial Institution: | Type of Account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings |
| Routing Number (Must be 9 digits): | Account Number: |

- I do NOT authorize direct deposit.
- Check One: Mail check to my home address. Call me to pick up my check.

(Special Tax Notice Regarding Plan Payments (if applicable))

- Federal law requires that 20% of the taxable portion of my payment (match contributions & earnings) be withheld for income tax purposes unless I elect to have the Plan directly transfer my payment to an Individual Retirement Account or another employer sponsored qualified retirement plan.
- If the value of my Plan benefit exceeds \$5,000. I am not required to receive a distribution of my Plan benefits until I reach my Normal Retirement Date under the Plan.

Part 4 DIRECT TRANSFER INFORMATION

| | | | |
|--|-------|------------------------|-------------|
| Name of Individual Retirement Account <input type="checkbox"/> or Employer's Plan <input type="checkbox"/> | | Make Check Payable To: | |
| Address: | | Contact Person: | |
| City | State | Zip Code | Phone No. |
| | | | Account No. |

The IRA/Employer's Plan will accept the following type of contributions: Pre-tax funds only Pre-tax and *Post-tax funds

I hereby acknowledge that pursuant to the terms of the above-named plan, such plan will accept the transfer of the above-named participant's account.

Date: _____ Name: _____ Title: _____ Phone Number: _____

***SIGNATURE IS REQUIRED WHEN ACCEPTING POST-TAX FUNDS**

Part 5 PARTICIPANT'S SIGNATURE

I hereby authorize the County to take such actions as are necessary to effectuate my election in Part 2 above. I understand that payments shall be made until such time as my account has been fully distributed. I further understand that my election, once made, is irrevocable. I have read the above Special Tax Notice Regarding Plan Payments (if applicable), and hereby represent that I understand the notice.

| | |
|-----------|------|
| Signature | Date |
|-----------|------|

TO BE COMPLETED BY RETIREMENT DEPARTMENT

| | | |
|----------------------------------|------|--------------------|
| Plan Administrator Authorization | Date | Post Tax Amount \$ |
|----------------------------------|------|--------------------|