



Now that you are retired!!!

AFTER YOU RETIRE

To better serve you as one of the City of Gainesville's retirees the Risk Management Department has developed this publication to help you with questions that may arise after you leave employment.

YOUR RETIREMENT BENEFIT PAYMENT

Your monthly retirement benefit payment will be credited to your account on **the last day of the month**. Retirement benefit payments will be transferred electronically to your account at your bank or other financial institution by direct deposit through Electronic Funds Transfer. No check will be written and mailed to you or your bank. Direct deposit offers you convenience, security, and peace of mind. There is no chance of your check being lost or delayed. If you retired in the middle of a month your first payment will be a partial payment for the actual time you are retired. Your full retirement check will begin the following month. Your first payment will be issued as a check to address on record with the City of Gainesville. Direct Deposit begins with your second monthly benefit payment. **Direct Deposit statements will be issued at the end of each year.**

CHANGES TO YOUR DIRECT DEPOSIT OR W4P

Changes to your Direct Deposit or W4P are done through the payroll department. If you change your account number, change your bank or other financial institution, please contact the Payroll Department at 352-334-5057 or by email cityret@ci.gainesville.fl.us to request the direct deposit form. After you have completed the form it can be mailed to

City of Gainesville Payroll Department
PO Box 490 Station 15
Gainesville, FL 32602

or faxed to 352-334-2271. Do not forget to attach a voided check to the form. REMEMBER: If you do not submit a direct deposit form no payment will be made to you until this form is completed.

If you wish to change your income tax withholding you will need to complete a new W4P. These forms are available through the IRS website www.irs.ustreas.gov/formspubs/ or the Payroll Department. After completion you need to submit the W4P to the Payroll Department at:

City of Gainesville Payroll Department
PO Box 490 Station 15
Gainesville, FL 32602

ADDRESS CHANGES

Address changes are done through the Human Resource Department on a change of address form. These requests should be in writing to insure accuracy. Important information and documents (such as your annual 1099R and your annual recertification cards) are mailed to your home address. Please be sure to inform Risk Management immediately of any change in your home mailing address for Health Insurance purposes.

NAME CHANGES

If your name changes while you are retired please notify Human Resources. They will need to see your social security card with your new name in order to make any changes. If you are on the City's Retiree Health Insurance you will also need to notify Risk Management so the Plan has your correct name on your policy.

COST OF LIVING INCREASES (COLA)

COLA increases are reflected on your October retirement check (issued October 31) following your birthday. These increases will be implemented according to the ordinance provisions governing your retirement benefit as stated in the City of Gainesville's Code of Ordinances.

General Pension Plan after 10/1/2000

20 to 25 years of service COLA begins at age 62

25 or more years of service COLA begins at age 60

Consolidated Retirement Plan (Police & Fire)

20 to 25 years of service COLA begins at age 62

25 or more years of service COLA begins at age 55

Using the rule of 70 COLA begins at age 62

POST TAX PENSION PLAN CONTRIBUTIONS

Pension Plan contributions made through December 31, 1997, were made after you had paid Federal Withholding Taxes on the amounts contributed. At retirement, you will begin receiving these contributions as part of your monthly pension check based on your life expectancy as determined by the IRS. That amount attributable to your contributions is tax-free income since you have paid the taxes on it at the time you made the contributions.

At retirement you were given a letter stating the amount you had paid in already taxed contributions. In order to determine the amount of tax-free income you can claim each year, you or your tax preparer should obtain **IRS PUBLICATION 575, PENSION & ANNUITY INCOME**. This publication explains how you can determine the amount of your total retirement income that is taxable and the amount of your retirement income that is not taxable. If you have lost your letter indicating your contributions contact Risk Management (352-334-5045) and you will be given your post tax contributions again.

ANNUAL RECERTIFICATION

Each year you will be required to recertify as a retiree of the City. You will be asked to sign a document in front of a notary or a Risk Management Representative. Notification for recertification will be mailed to you.

SURVIVOR BENEFITS

The Risk Management Department should be informed shortly after either your death or your joint annuitant's death. Your beneficiary will be informed if any future benefits are payable and if any forms need to be completed. Your estate is entitled to the full monthly benefit paid at the end of the month of your death. Example—Retiree dies April 2, the full monthly retirement will be paid to the estate or beneficiary.

HEALTH INSURANCE

Upon retirement you will be sent notification from COBRA. If you have elected to remain on the City's Health Insurance Plan or have elected insurance somewhere else, please disregard this notice. You do not need to do anything unless you are wishing to continue your dental or vision insurance you had upon retiring for 18 months.

If you have elected the City of Gainesville's retiree health insurance and do not see the deduction from your 2nd retirement check, contact Risk Management to clarify any issues that may have accidentally occurred. This deduction may not appear on your first check however don't be concerned, this is a timing issue for paperwork completion.

There is no rate reduction in your City Health Insurance upon reaching Medicare eligibility. However to receive the most benefit through both Medicare and the City's Retiree Health insurance you need to elect Part B of Medicare.

As a reminder regardless of your present coverage under the Retiree Health Insurance plan, **you will be allowed to opt out of the plan and re-enter only one time at a future date.** To do so you must contact the Risk Management Department.

Annually you will receive notification to enroll in the City of Gainesville's Health Insurance for retirees. These meetings are usually scheduled for the fall and are for the plan changes beginning in January of the next year.

Changes to your Health Insurance can only be made during Open Enrollment or if you have encountered a qualifying event such as coverage through another employer, marriage, divorce, or termination or commencement of your spouse's employment which results in the gaining or loss of eligibility for coverage. Changes occurring due to a qualifying event must be made within 30 days of the event. Contact the Risk Management Department for further assistance.

Reminder: You need to **sign up for Medicare** A & B close to your 65th birthday, even if you will not be retired by that time. (If you are getting Social Security benefits when you turn 65, your Medicare Hospital Benefits start automatically.)

RETIREE HEALTH SAVINGS (RHS)

If you have a RHS account and wish to be reimbursed from your account you must complete the claim form and attach copies of the receipts you are wishing to be reimbursed for. This is then mailed to the address at the bottom of the reimbursement form. Only medical expenses are eligible for reimbursement, including health insurance premiums, vision and dental care.

CITY LIFE INSURANCE

The City of Gainesville paid for life insurance for you while you were an active employee of the City. When you retired this benefit reduced to 1/2 of what it was while you were an active employee up to a maximum of \$50,000. Each year on the anniversary of your retirement this benefit reduces approximately \$5000 per year until it reaches \$5000 at which point it will remain until such time as your beneficiary applies for the benefit following your death. The beneficiary of your City life insurance policy is listed on the card you completed while still employed with the City. If you have a change to whom you wish your life insurance to be paid, please update your beneficiary card ASAP through the Risk Management Department (352-334-5045) where all claims must be filed. A certified copy of your death certificate stating the cause of death is needed for processing the claim.

REHIRED RETIREES

As a retiree you may become rehired by the City of Gainesville. If you do so you will begin as a new member of the pension plan and earn credited service towards an additional retirement benefit. Your prior service credit may not be used towards your reemployment. As a rehired retiree you may not purchase any additional credit for service performed prior to re-employment and you will not be entitled to a disability retirement. You will be entitled to all benefits offered to regular active employees. In some areas there is a one year waiting period prior to becoming eligible for reemployment.

EMPLOYEE HEALTH SERVICES

As a retiree you are still able to use the services provided by Employee Health Services. Please call 352-334-5037 for an appointment. Not all services are free however many are. The following are examples of services available to you:

- Tetanus injections
- Flu shots (retirees & spouses)
- Blood Pressure and Blood Sugar checks
- Hepatitis A & B vaccines
- Blood Draws – Health Panel (includes electrolytes, iron, kidney function, liver function, glucose, cholesterol) and PSA

You can also get blood work done at Doctors Lab at the City's discounted price.

LIFE QUEST

As a retiree of the City of Gainesville, you are still eligible to participate in the City's Life Quest Program. Visit the website at www.lifequest.cityofgainesville.org for more information.

RETIREMENT ANNUITY OPTION DESCRIPTIONS

The Option Election you have chosen is designated on your Application for Pension and/or your Option Election Form. The options were explained to you at the time you elected to retire or to enter the DROP. Below is a description of the options as explained to you at that time.

CONSOLIDATED RETIREMENT PLAN (POLICE & FIRE)

LIFE ANNUITY WITH 10 YEAR LIFE & CERTAIN – One hundred percent benefit payable to the retiree. Upon death of retiree, all benefits stop except in the event the retiree has not received a retirement benefit for 10 years, this benefit will continue to the named beneficiary or beneficiaries until benefits have been paid for 10 years following retirement.

LIFE ANNUITY - One hundred percent of benefit payable to the retiree. Upon death of retiree, all benefits stop.

JOINT AND SURVIVOR - Actuarial reduced benefit payable to the retiree, based upon a 10 year Life & Certain benefit. At retiree's death only, two-thirds (2/3) of retiree's benefit is payable to a designated beneficiary for the remainder of the beneficiary's life.

JOINT AND LAST SURVIVOR - Actuarial reduced benefit payable to the retiree, based upon a 10 year Life & Certain benefit. At the death of **either** the retiree **OR** beneficiary, whoever shall remain living shall receive benefits based upon the designated percentage elected below.

- 100% of benefit continues
- 75% of benefit continues
- 66% of benefit continues
- 50% of benefit continues

GENERAL EMPLOYEE'S PENSION PLAN

LIFE ANNUITY - One hundred percent of benefit payable to the retiree. Upon death of retiree, all benefits stop.

JOINT AND SURVIVOR - Actuarial reduced benefit payable to the retiree. At retiree's death only, two-thirds (2/3) of retiree's benefit is payable to a designated beneficiary for the remainder of the beneficiary's life.

JOINT AND LAST SURVIVOR - Actuarial reduced benefit payable to the retiree. At the death of **either** the retiree **OR** beneficiary, whoever shall remain living shall receive two-thirds (2/3) of the retiree's benefit for the remainder of the survivor's life.

SOCIAL SECURITY - Designed to provide a more or less level income for life. Retiree receives a higher City benefit (over and above Life Annuity benefit) before age 65, and a lesser City benefit after age 65. However, at age 65 City benefit plus Social Security benefit will approximately equal pre-65 income.

CONTACTS TO KNOW

City of Gainesville

Risk Management Department 352-334-5045 Fax # 352-334-3102

222 East University Ave.

Station 60

Gainesville, FL 32601

Email DG_riskwebinfo@cityofgainesville.org

Payroll Department 352-334-5057 Fax # 352-334-5057

200 East University Ave.

Station 15

Gainesville, FL 32601

Email cityret@cityofgainesville.org

Employee Health Services 352-334-5037

222 East University Ave.

Station 44

Gainesville, FL 32601

Human Resources Department 352-334-5077 Fax # 352-334-2055

222 East University Ave.

Station 20

Gainesville, FL 32601

ICMA Retirement Corporation 1-800-669-7400 www.icmarc.org

Local representative is Adam Ferguson 1-866-328-4672

457 Deferred Compensation, Roth IRA & Retiree Health Savings

VantageCare Retirement Health Savings (RHS)

c/o Mertain Health, Inc.

P.O. Box 30111

Lansing, MI 489119-7611

1-888-587-9441

BLUE CROSS claims – 1-800-322-2808

Donna Davis 352-337-2511 X24107

www.bcbsfl.com

Social Security Gainesville Office 375-4178

www.socialsecurity.gov (request a Social Security Statement)

Social Security Retirement Planner www.ssa.gov/retire2/

IRS www.irs.ustreas.gov/formspubs/

IRS withholding calculator www.irs.gov/individuals/index.html

**Withholding Certificate for
Pension or Annuity Payments**

2008

Purpose. Form W-4P is for U.S. citizens, resident aliens, or their estates who are recipients of pensions, annuities (including commercial annuities), and certain other deferred compensation. Use Form W-4P to tell payers the correct amount of federal income tax to withhold from your payment(s). You also may use Form W-4P to choose (a) not to have any federal income tax withheld from the payment (except for eligible rollover distributions, or payments to U.S. citizens delivered outside the United States or its possessions) or (b) to have an additional amount of tax withheld. Your options depend on whether the payment is periodic, nonperiodic, or an eligible rollover distribution, as explained on

pages 3 and 4. Your previously filed Form W-4P will remain in effect if you do not file a Form W-4P for 2008.

What do I need to do? Complete lines A through G of the Personal Allowances Worksheet. Use the additional worksheets on page 2 to adjust your withholding allowances for itemized deductions, adjustments to income, certain credits, or multiple pensions/more-than-one-income situations. If you do not want any federal income tax withheld (see *Purpose* above), you can skip the worksheets and go directly to the Form W-4P below.

Sign this form. Form W-4P is not valid unless you sign it.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself if no one else can claim you as a dependent **A** _____

B Enter "1" if:
 { • You are single and have only one pension; or
 • You are married, have only one pension, and your spouse has no income subject to withholding; or
 • Your income from a second pension or a job, or your spouse's pension or wages (or the total of all) is \$1,500 or less. } **B** _____

C Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a spouse who has income subject to withholding or you have more than one source of income subject to withholding. (Entering "-0-" may help you avoid having too little tax withheld.) **C** _____

D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return **D** _____

E Enter "1" if you will file as head of household on your tax return **E** _____

F **Child Tax Credit** (including additional child tax credit):
 • If your total income will be less than \$58,000 (\$86,000 if married), enter "2" for each eligible child.
 • If your total income will be between \$58,000 and \$84,000 (\$86,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have 4 or more eligible children **F** _____

G Add lines A through F and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) **G** _____

For accuracy, complete all worksheets that apply.
 { • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
 • If you have more than one source of income subject to withholding or a spouse with income subject to withholding and your combined income from all sources exceeds \$40,000 (\$25,000 if married), see the **Multiple Pensions/More-Than-One-Income Worksheet** on page 2 to avoid having too little tax withheld.
 • If neither of the above situations applies, stop here and enter the number from line G on line 2 of Form W-4P below.

----- Cut here and give Form W-4P to the payer of your pension or annuity. Keep the top part for your records. -----

**Withholding Certificate for
Pension or Annuity Payments**

2008

▶ For Privacy Act and Paperwork Reduction Act Notice, see page 4.

Type or print your first name and middle initial.	Last name	Your social security number
Home address (number and street or rural route)		Claim or identification number (if any) of your pension or annuity contract
City or town, state, and ZIP code		

Complete the following applicable lines.

1 Check here if you do not want any federal income tax withheld from your pension or annuity. (Do not complete lines 2 or 3.) ▶

2 Total number of allowances and marital status you are claiming for withholding from each periodic pension or annuity payment. (You may also designate an additional dollar amount on line 3.) ▶ _____ (Enter number of allowances.)
 Marital status: Single Married Married, but withhold at higher "Single" rate

3 Additional amount, if any, you want withheld from each pension or annuity payment. (Note. For periodic payments, you cannot enter an amount here without entering the number (including zero) of allowances on line 2.) . . . ▶ \$ _____

Your signature ▶ _____ Date ▶ _____



VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) PLAN BENEFITS REIMBURSEMENT REQUEST FORM - Page 1 of 2

• Complete this form and send with supporting documentation to **VantageCare RHS Plan, c/o Meritain Health, Inc., P.O. Box 30136, Lansing, MI 48909-7611**. Supporting documentation (originals only, no copies) may consist of:

- Bills
- Explanation of Benefits
- Premium Notices
- Receipts

- A separate form must be completed for each eligible claimant.
- Each form of documentation must contain the date(s) of service, provider name, provider address, description of treatment, service or supply, as well as the name of the claimant.

PLEASE NOTE: Do **not** submit claims for charges eligible under your insurance or Medicare. Do **not** submit claims over two years old or claims for services provided prior to your benefit eligibility date.

Employer Plan Number _____	Employer Name _____	State _____	
Participant Name (Last, First and Middle Initial) _____		Address _____	
Social Security Number _____		Street _____	
Daytime Phone Number _____ <small>(Area Code) _____</small>		City _____	
		State _____ Zip Code _____	
<small>NOTE: If this is a new address, please contact ICMA-RC at 1-800-669-7400 to update your address. Your check will be mailed to the address on file with ICMA-RC.</small>			
Claim for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other Dependent <input type="checkbox"/> Non-Spouse or Non-Dependent Beneficiary			
Claimant's Full Name (Last, First and Middle Initial) _____			
Part A: Request for Reimbursement of Non-Recurring Expenses Use this section to request a reimbursement of non-recurring expenses (e.g., co-payments, medications, out-of-pocket expenses). Summary of Healthcare Expenses			
Incurred Date*	Provider (e.g. doctor name/ pharmacy name)	Description of Service	Amount To be Reimbursed
<small>* Incurred date is the date of service, not the billing or payment date.</small>			Total reimbursement request: \$ _____
Part B: Request for Reimbursement of Recurring Expenses Use this section to request automated reimbursement of recurring expenses (e.g. insurance premiums). Note: Payment must be made to the account holder. Payment will <u>not</u> be made directly to an insurance company or other third party. You are responsible for ensuring that automated reimbursements are for qualifying medical expenses. You are also responsible for ensuring that automated reimbursements are stopped if you are no longer incurring the expense(s). You must provide documentation of the recurring expense with this request, and you must retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.			

PLEASE RETAIN A COPY FOR YOUR RECORDS

(continued on page 2)

Send completed form to: VantageCare Retirement Health Savings (RHS) Plan, c/o Meritain Health, Inc., P.O. Box 30136, Lansing, MI 48909-7611 • 1-888-587-9441

FRM090-002-200705-C324



VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) PLAN BENEFITS REIMBURSEMENT REQUEST FORM - Page 2 of 2

Participant Name (Last, First and Middle Initial) _____

Social Security Number _____

1. **Begin** recurring reimbursement of \$ _____
 Beginning Date: Insert date you wish payments to begin ____/____/____
Month Day Year
 Frequency (Check one): Annual Quarterly Monthly Weekly
 Ending Date: Insert date automated payments should cease ____/____/____
Month Day Year
2. **Change** recurring payment amount to \$ _____
 Effective date of change ____/____/____
Month Day Year
3. **End** recurring payment of \$ _____
 Ending Date: Insert date automated payments should cease ____/____/____
Month Day Year

Note: Payments will continue until your account is depleted, unless an ending date is provided. Any changes to your payment must be received by Meritain health at least 10 business days prior to the effective date of the change. Otherwise the change will take effect on the next scheduled reimbursement. Your account balance may be obtained via Account Access at (www.icmarc.org) or VantageLine at 1-800-669-7400.

For Meritain Health Use Only	
PM	
PD	
PL	
PC	

READ CAREFULLY

The undersigned certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, the participant's eligible dependents, or a designated beneficiary (after the participant's death only) while the undersigned was eligible to receive benefits under the RHS Plan. The undersigned also certifies as follows:

- The medical expenses have not been reimbursed and are not reimbursable under any other health/dental plan or Medicare.
- Non-prescription medications for which reimbursement is requested were purchased to alleviate or treat personal injuries or sickness.
- The undersigned is responsible for requesting cessation of automated reimbursement of recurring expenses when the expense is no longer being incurred, and will retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

The undersigned understands that he/she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. The undersigned understands that he/she will be liable for payment of all related taxes including Federal, state or local income tax on amounts paid from the Plan for non-qualifying expenses.

Participant Signature _____

Date _____

PLEASE RETAIN A COPY FOR YOUR RECORDS

Send completed form to: VantageCare Retirement Health Savings (RHS) Plan, c/o Meritain Health, Inc., P.O. Box 30111, Lansing, MI 48909-7611 • 1-888-587-9441

DIRECT DEPOSIT AUTHORIZATION AGREEMENT

I hereby authorize **THE CITY OF GAINESVILLE, FLORIDA**, hereinafter called **CITY**, to **change** credit entries to the account indicated below and the **DEPOSITORY**, to credit the same such account.

EMPLOYEE NAME: _____

EMPLOYEE _____ IDENTIFICATION NUMBER: _____

DEPOSITORY (Bank/Credit Union) NAME: _____

CITY _____ STATE _____ ZIP _____

BK/TRANSIT/ABA NO.: _____

Account Number

Account Type

Amount to be Deposited

(Checking or Savings)

(Net Pay or Specific \$ Amount)

This authority is to remain in full force and effect until the CITY has received written notification from me of its termination in such time and in such manner as to afford the CITY a reasonable opportunity to act on it.

AVAILABILITY OF FUNDS IS SUBJECT TO ABOVE NAMED DEPOSITORY POLICY AND/OR PROCEDURE.

Employee Signature _____ Date _____

DO NOT WRITE BELOW THIS LINE

Payroll Code: _____ Post Date: _____

Checking _____ Savings _____

Effective Pay Date _____

ATTACHED VOIDED CHECK HERE

Return to City of Gainesville
Payroll Department
200 E University Ave Station 15
Gainesville, FL 32602

ADDRESS AND INFORMATION CHANGE FORM

Name: _____ ID # _____

EMPLOYEE INFORMATION

HOME ADDRESS

MAILING ADDRESS

Street: _____

Street: _____

City: _____ State: _____

City: _____ State: _____

Zip: _____ - _____

Zip: _____ - _____

Home Phone: _____

EMPLOYEE NAME CHANGE

****ATTACH COPY OF UPDATED SOCIAL SECURITY CARD****

Previous Name: _____

New Name: _____

Effective Date: _____ Reason: _____

EMPLOYEE MARITAL STATUS

****PLEASE REMEMBER TO UPDATE YOUR BENEFICIARY INFORMATION AT RISK MANAGEMENT****

Marital Status: _____

EMERGENCY CONTACT INFORMATION

FIRST CONTACT

SECOND CONTACT

Name: _____

Name: _____

Relation: _____

Relation: _____

Street: _____

Street: _____

City: _____ State: _____

City: _____ State: _____

Zip: _____ - _____

Zip: _____ - _____

Home Phone: _____

Home Phone: _____

Work Phone: _____

Work Phone: _____

Employee Signature _____ Effective Date _____

NOTE: If you have a 457 account, they must be notified separately. Call 1-800-669-7400

Return this form to the
City of Gainesville Human Resources Department
222 E University Ave. Station 20
Gainesville, FL 32602