FPPA

Fire and Police Pension Association
5290 DTC Parkway
Greenwood Village, Colorado 80111
(303) 770-3772 • Toll Free: (800) 332-3772

AUTHORIZATION FOR PREMIUM DEDUCTIONS

AARP® Medicare Supplement Insurance Plan and/or AARP® MedicareRx Plans

Insured Through UnitedHealthcare.

INSTRUCTIONS:
- Please do not fax this form, only original forms will be accepted.
- Please print or type all information.
- Complete the entire form and follow the specific instructions for each section.

SECTION 1: RETIREE INFORMATION

Dear Member: The purpose of this form is to elect into the FPPA Premium Deduction Program This authorization form should only be completed if you currently have an existing AARP Medicare Supplement Insurance Plan and/or AARP MedicareRx Plan through UnitedHealthcare.

_____________ _____ _________________ ____ / ____ / ______ ____ / ____ / ______
Member's First Name M.I. Last Today's Date *(mm/dd/yyyy)* Social Security Number

_________________________ ____________ ________ ________
Mailing Address City State ZIP

(______) ______ - __________ (______) ______ - __________ ________________
Daytime Area Code and Telephone Number Evening Area Code and Telephone Number Email Address

____
Employment at Retirement - City / Department Name

SECTION 2: POLICY INFORMATION

INSTRUCTIONS: List all of the policy information for the plans that you would like to have included in the FPPA Premium Deduction Program. You can include any premium that is currently billed to you and paid by you via bank draft, electronic funds transfer or other method of payment.

▸ ____________ ______ ______________ ________________
Name on Policy *(first / middle initial / last)* Relationship to Member *(self, spouse, dependent)*

________________ $ ________.____ Insurance Type:
AARP Account # Monthly Premium Amount or then current monthly premium amount ☐ AARP Medicare Supplement Insurance Plan ☐ AARP Medicare Rx Plans

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▸ ____________ ______ ______________ ________________
Name on Policy *(first / middle initial / last)* Relationship to Member *(self, spouse, dependent)*

________________ $ ________.____ Insurance Type:
AARP Account # Monthly Premium Amount or then current monthly premium amount ☐ AARP Medicare Supplement Insurance Plan ☐ AARP Medicare Rx Plans

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▸ ____________ ______ ______________ ________________
Name on Policy *(first / middle initial / last)* Relationship to Member *(self, spouse, dependent)*

________________ $ ________.____ Insurance Type:
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▸ ____________ ______ ______________ ________________
Name on Policy *(first / middle initial / last)* Relationship to Member *(self, spouse, dependent)*

________________ $ ________.____ Insurance Type:
AARP Account # Monthly Premium Amount or then current monthly premium amount ☐ AARP Medicare Supplement Insurance Plan ☐ AARP Medicare Rx Plans

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SECTION 3: RETIREE ACKNOWLEDGMENT

- I understand that I am electing to have premiums for my coverage in an eligible Medicare Supplement and/or Medicare Prescription Drug Plan with AARP through UnitedHealthcare deducted from my pension payment rather than billed to me.
- I understand that my Medicare Supplement Plan and/or Medicare Prescription Drug Plan coverage will continue as issued by United HealthCare Insurance Company and is not provided in affiliation with FPPA. My enrollment in the FPPA Insurance Premium Deduction Program will not result in lower premiums or any other unique benefits.
- I authorize FPPA to pay the premiums directly to United HealthCare Insurance Company and deduct the cost from my monthly pension benefit.
- I understand that by making this election, UnitedHealthcare will no longer send an invoice to me nor will they withdraw premium payments from my bank account for the insurance plans authorized on this form.
- I understand that participation in the FPPA Premium Deduction Program does not guarantee that I qualify for the Pension Protection Act tax exclusion. Section 845 of the Pension Protection Act allows public safety officers to elect to exclude up to $3,000 of distributions from a governmental qualified retirement plan from taxable income as long as the payments are made directly to an insurer to purchase health care, or a prescription drug plan for the officer or the officer's spouse and/or dependents.
- I understand that I cannot participate in the FPPA Premium Deduction Program if the premium(s) exceed my monthly retirement benefit.
- I understand that the FPPA Premium Deduction Program is available to my beneficiary upon my death. The exclusion of up to $3,000 from taxable income under the Pension Protection Act is not available to beneficiaries upon the member’s death.

_____ _____ / _____ / _____

Retiree Signature Today's Date *(mm/dd/yyyy)*

RETAIN A COPY FOR YOUR RECORDS