New Hampshire Retirement System
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ANNUITY DEDUCTION AUTHORIZATION – POLITICAL SUBDIVISIONS

SECTION I - INSTRUCTIONS

This form is to be used by individuals qualified to receive a service retirement, disability retirement or survivor annuity (the "Annuitant") to authorize the deduction of medical and/or dental coverage premiums from the monthly annuity payments. If an Annuitant and his or her spouse are both receiving a retirement annuity from NHRS and will be covered under the medical plan of only one of their former employers, then submit one form for both retirees. If an Annuitant and his or her spouse are both receiving a retirement annuity from NHRS and will be covered under both of the medical plans of the former employers of both retirees, then submit a form for each retiree.

- **The Annuitant must complete sections II and V and return the form to the former employer**
- **The former employer must complete sections III and V and submit the form to NHRS**
- **This is a two-page form – please complete both pages – incomplete forms will be returned and may result in a delay in processing**
- **Please type or print all entries**

SECTION II - ANNUITANT INFORMATION *(To be completed by the Annuitant)*

Annuitant Name *(Last, First, MI)*:	☐ M ☐ F	Social Security #:
Annuitant is ☐ Member ☐ Surviving Spouse ☐ Surviving Child		
Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced		
Spouse Name*(Last, First, MI)*:	☐ M ☐ F	Social Security #:
Mailing Address *(PO/Street, City, State, Zip)*:		
Telephone Number: ( )	Email Address:	
Member Retired as a Political Subdivision: ☐ Employee ☐ Teacher ☐ Police ☐ Fire		

SECTION III - FORMER EMPLOYER INFORMATION *(To be completed by former employer)*

Employer Name:	Telephone Number: ( )	
Mailing Address *(PO/Street, City, State, Zip)*:		
Group Number:	Provider Number:	Employer Contact:

SECTION IV - PREMIUM DEDUCTION INFORMATION *(To be completed by former employer)*

Effective Date of Request:		**Requested Action:** New, Change, No Change, Cancel, Subsidy Only
1. Retired Member Premium, Health	$	
2. Spouse Premium, Health	$	
3. Dental Plan and/or Vision Plan (if applicable)	$	
4. Qualified Children Premium	$	
5. Total Monthly Rate (line 1 + line 2 + line 3)	$	
6. Expected Medical Subsidy (if applicable)	$	
7. Retirement Annuity Deduction (line 5 minus line 6)	$	

SECTION V - PLEASE READ, SIGN, AND DATE BELOW *(To be completed by the Annuitant)*

LIFE EVENTS

If you are qualified for a Medical Subsidy, you must notify NHRS within 30 days if any of the following events occur:

- Any change in marital status of the Retiree,
- The death of a spouse of the Retiree,
- The remarriage of a surviving spouse of a deceased Retiree or deceased Member;
- A qualified certifiably dependent disabled child no longer resides in the household;
- A surviving spouse of a member who died in the line of duty remarries or becomes eligible to receive medical insurance or health coverage from any employer-sponsored plan (even if the individual declines to enroll in such plan);
- The attainment of 18 years of age (23 if a full-time student) by the surviving child of a member who died in the line of duty or if such child becomes eligible to receive medical insurance or health coverage from any employer-sponsored plan (even if the individual declines to enroll in such plan).

ENTITLEMENT TO MEDICARE

The amount of the Medical Subsidy is reduced when a qualified person becomes "entitled to Medicare". The reduction applies to entitlement to both Part A coverage (hospitalization) and Part B coverage (supplementary medical insurance) regardless of whether the entitled individual actually enrolls or pays for such coverage. Every annuitant is required to notify NHRS within 30 days of when any person qualified for a Medical Subsidy becomes entitled to Medicare because of attaining age 65 or because of the receipt of Social Security disability benefits (generally after receiving Social Security disability benefits for 24 months).

Are you entitled to Medicare at this time?	YES: ☐	NO: ☐
Is your spouse entitled to Medicare at this time?	YES: ☐	NO: ☐
Is your dependent child disabled child entitled to Medicare a this time?	YES: ☐	NO: ☐

CERTIFICATION AND SIGNATURE

I hereby authorize NHRS to deduct from my monthly retirement annuity the amount of monthly premiums I owe with respect to my coverage under the medical and/or dental plan of the former employer named above. The initial amount of such deduction is provided above in Section III. This authorization shall apply, without further notice to me, to any change in the amount to be deducted because of (a) any change in premium costs or changes in coverage under the former employer's plan or (b) any change in the amount of any Medical Subsidy for which I, my spouse or my children are qualified pursuant to RSA 100-A:50-55. I understand that eligibility for the Medical Subsidy is conditioned upon my being covered under the medical plan of the former employer named above.

If it is determined by NHRS that I qualify for the Medical Subsidy, all subsidy amounts payable on behalf of me, my spouse and any qualified children will be paid directly to my former employer and will be applied on my behalf to reduce the amount of premium I owe each month. The balance of the premium due, if any, will be deducted from my monthly retirement annuity effective as of the first of the month following attainment of Medical Subsidy eligibility.

Change in Eligibility Status: I understand that the amount of Medical Subsidy for which I am qualified may change due to a change in life events described above or entitlement to Medicare as provided in RSA 100-A:50-55. I hereby agree to notify NHRS within 30 days following the occurrence of any of the life events listed above or if I, my spouse or any qualified child becomes entitled to Medicare. In this regard, I hereby certify that I have read and understand the information provided above which describes when I am required to notify NHRS. I also agree to complete and timely file an annual Eligibility Questionnaire regarding my eligibility for the Medical Subsidy.

I understand that NHRS reserves the right to recover all Medical Subsidy amounts paid on behalf of me, my spouse or former spouse, or any qualified child who has lost Medical Subsidy eligibility, and/or all overpayments resulting from my failure to report entitlement to Medicare as described above.

I hereby attest, under penalties of perjury, that the information provided above is true to the best of my knowledge and belief.

Annuitant Signature:	Date:
Spouse Signature:	Date:

SECTION VI - FOR NHRS USE ONLY

Med Sub: ☐ Yes ☐ No	Payroll Date:	Process Date:	Initials: