

PALM BEACH COUNTY FIREFIGHTERS' RETIREMENT INSURANCE FUND

www.pbcretiree.com

7240 7th Place N
West Palm Beach, FL 33411

Phone (561) 209-2523

Located inside the PBC Firefighters Benefits Fund Offices

Trustees

Rick Rhodes - Chairman
Michael Bergeron – Administrative Manager
John Flaherty Vice - Chairman
David Toohey – Union Appointee
Jim Berry
Craig Gerlach
David Horowitz
Michael Basalice III

Questions about benefits? Call

Mike Bergeron 561.209.2523

or

Rick Rhodes 561.436.4714

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7240 7th PL N
WEST PALM BEACH, FL. 33411
(561) 209-2523

Dear Retiree:

Enclosed, you will find an application and the plan document explaining the benefit levels and eligibility requirements. The following documentation must be filled out completely and returned to this office:

- Signed original application
- Completed signed beneficiary form
- Proof of retirement
- Proof of insurance
- Copy of driver's license

Upon review and verification of your information and eligibility, your benefit will be applied each year to offset the cost of your health insurance premiums with PBC Firefighters Employee Benefits Fund. If you have different health insurance as noted above, your benefit will be provided to you in the form of a credit card from Anchor Benefit Consulting with instructions on how to use it.

Thereafter, each December only for Anchor Benefit card holders, an affidavit for continued eligibility will be mail to you which must be filled out and returned to Anchor Benefit along with proof of insurance. Upon receipt of the affidavit and proof of health insurance, your new benefit amount will then be added to your credit card. Any unused balances from previous years will roll forward.

If you have any questions, or need any additional information, please don't hesitate to contact me at (561) 209-2523.

Sincerely,

Michael Bergeron
Administrative Manager

**PALM BEACH COUNTY FIREFIGHTERS' RETIREMENT INSURANCE FUND
APPLICATION FOR BENEFITS FORM**

PERSONAL INFORMATION

NAME: _____	SS#: _____	
ADDRESS: _____	CITY/ST/ZIP: _____	
PHONE: _____	EMAIL: _____	AGE: _____
DOB: _____	LAST DATE OF EMPLOYMENT: _____	#PBCFR Years _____
NAME OF SPOUSE: _____	DATE OF HIRE: _____	# FRS Years: _____
# YEARS IN BARGAINING UNIT: _____	# YEARS IN NON BARGAINING UNIT: _____	

PENSION INFORMATION

Are you currently receiving a pension or disability benefit? Yes _____ No _____				
If Yes — what type: Pension _____ Disability _____				
Source of Benefit: (Circle one)	FRS	Lantana or LW Pension Fund	Long-term Disability under CBA	Other Lump Sum etc.
Date Payments Began: _____				

HEALTH INSURANCE INFORMATION

HEALTH INSURANCE CO: _____	PHONE #: _____
ADDRESS: _____	
CITY/ST/ZIP: _____	ANNUAL PREMIUM \$ _____
POLICY #: _____	GROUP #: _____

IMPORTANT: In order to be eligible to receive a benefit from the Fund, you must attach to this Application a copy of your benefit check stub or other proof of receipt of a pension or disability benefit **and** a copy of your current health insurance card. This benefit must be used for the purchase of health insurance or other qualified medical expenses.

I HEREBY STATE THAT THE INFORMATION I HAVE PROVIDED ON THIS FORM IN ORDER TO RECEIVE A BENEFIT FROM THE FUND IS TRUE AND ACCURATE.

SIGNATURE

DATE

Designation of Beneficiary

Policyholder	PALM BEACH COUNTY FIREFIGHTERS' EMPLOYEE BENEFITS FUND	Policy Number(s)	GL 160157 (BASIC)
Insured Name		Social Security Number	

I hereby designate the following as my beneficiary (ies) under the above policy number(s):

Primary Beneficiary(ies)

Full Name and Address (Please Print)	Percentage* (Must total 100%)	Date of Birth	Relationship	Social Security Number

* If no percentages are indicated, benefits will be divided equally between all primary beneficiaries.

Contingent Beneficiary(ies) (applicable only if you are not survived by one or more primary beneficiaries)

Full Name and Address (Please Print)	Percentage* (Must total 100%)	Date of Birth	Relationship	Social Security Number

* If no percentages are indicated, any benefits payable to contingent beneficiaries will be divided equally between all contingent beneficiaries.

- ! This beneficiary designation revokes all revocable prior beneficiary designations.
- ! Unless you indicate otherwise, if any beneficiary predeceases you, that beneficiary's share will be divided pro-rata among the surviving beneficiaries of the same class (primary or contingent).
- ! If no beneficiary (primary or contingent) survives you, payment will be made pursuant to the terms of the applicable policy.

Date	Signature of Insured
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Plan Highlights

Group Basic Life Insurance



Palm Beach County Firefighters Employee Benefits Fund

ELIGIBILITY

Class 1:

All full-time bargaining unit employees of Palm Beach County Fire Rescue in pay status, all full-time non-bargaining unit employees of Palm Beach County Fire Rescue in pay status that are participants in the Palm Beach County Firefighters Employee Benefits Fund, all full-time employees of the Professional Firefighters/ Paramedics of Palm Beach County, Local 2928 IAFF, Inc. in pay status, and all full-time employees of the Palm Beach County Firefighters Employee Benefits Fund in pay status, and all full-time employees of the Palm Beach County Firefighters Health Clinic LLC in pay status.

Class: 2

All retired bargaining unit employees of Palm Beach County Fire Rescue, all retired non-bargaining unit employees of Palm Beach County Fire Rescue that are participants in the Palm Beach County Firefighters Employee Benefits Fund, all retired employees of the Professional Firefighters/Paramedics of Palm Beach County, Local 2928 IAFF, Inc., that are participants in the Palm Beach County Firefighters Employee Benefits Fund, and retired employees of the Palm Beach County Firefighters Employee Benefits Fund that are participants in the Palm Beach County Firefighters Employee Benefits Fund and retired employees of the Palm Beach County Firefighters Health Clinic LLC that are participants in the Palm Beach County Firefighters Employee Benefits Fund.

BENEFIT AMOUNT- Class 1

Basic Life Employee: \$100,000

BENEFIT AMOUNT – Class 2

Retiree: \$50,000

VALUE ADDED SERVICES

- ▶ Bereavement Counseling Service
- ▶ Travel Assistance Service
- ▶ Identity Theft Recovery Services

CONTRIBUTION REQUIREMENTS

Coverage is employer paid.

BENEFIT REDUCTION DUE TO AGE - Class 1

Age	Original Benefit Reduced To
70	65%
75	50%

BENEFIT REDUCTION DUE TO AGE - Class 2

Age	Original Benefit Reduced To
70	50%

EXCLUSIONS

For a comprehensive list of exclusions and limitations, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

This Plan Highlights is a brief description of the key features of the RSL insurance plan. The availability of the benefits and features described may vary by state. It is not a certificate of insurance or evidence of coverage.

Insurance is provided under group policy form LRS-6422, et al.

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