



County *of* Galveston

---

Department of Human Resources

# Retirement

## Employee Guide & Forms

GALVESTON COUNTY DEPARTMENT OF HUMAN RESOURCES

# Retirement Guide Book & Forms

---

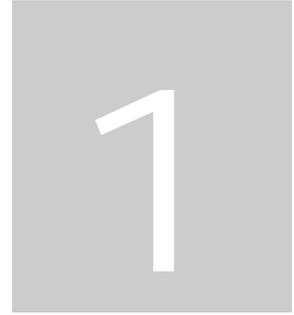
County of Galveston  
Human Resources  
722 Moody • 3<sup>rd</sup> Floor  
Galveston, TX 77550  
Phone 409.770.5418 • Fax 409.770.5351

---

# Table of Contents

<b>Subject</b> .....	<b>Section/Form</b>
Retirement Eligibility.....	1
Retirement Systems & Contacts .....	2
TCDRS/Pension.....	3
<i>Service Retirement Application</i> .....	<i>TCDRS-22</i>
<i>Retirement Option Selection</i> .....	<i>TCDRS-23</i>
<i>Income Tax Withholding</i> .....	<i>TCDRS-73</i>
<i>Direct Deposit Authorization</i> .....	<i>TCDRS-70</i>
AUL/Social Security Alternate .....	4
<i>Separation from Service Distribution</i> .....	<i>R-19126-1</i>
<i>Electronic Fund Transfer</i> .....	<i>R-18608</i>
Life Insurance Policy .....	5
<i>RLR Application</i> .....	<i>Form #102G</i>
Medical Coverage .....	6
<i>Boon-Chapman</i> .....	<i>Benefit Status Form</i>
<i>Galveston County Treasurer</i> .....	<i>Payment Authorization</i>
Other Optional Benefits.....	7
Final Check & Payouts.....	8
<i>Authorization to Release Pay</i> .....	<i>Release Form</i>
Future Notices & Communication .....	9
Human Resources Checklist.....	End

---



## Retirement Eligibility

*This section will help you determine whether you will qualify to retire*

**T**here are two different ways in which you can retire with Galveston County. You may qualify to retire based on your years of service and age or you may meet certain requirements to qualify for retirement based on a disability. Both options have their own set of requirements and guidelines.

### Service Retirement:

Once you are vested (8 years of service) with the County, you are eligible for a monthly retirement benefit through TCDRS when you meet one of the following requirements:

- Age 60 with 8 years of service; or
- Any age with 30 years of service; or
- Age plus your years of service equals 75 (also called the Rule of 75 or Points).

### Disability Retirement:

You may be able to medically retire through TCDRS based on a qualifying medical or psychological disability.

- 4 year vesting period if your disability was work related
- 8 year vesting period if your disability is non-work related

### Important Note

Service time with sister systems of TCDRS or service with another Texas county can count towards your vesting period with Galveston County. Other Texas public retirement system accounts are:

Employees Retirement System of Texas (ERS), Texas Municipal Retirement System (TMRS), City of Austin Employees Retirement System (COAERS), Teacher Retirement System of Texas (TRS) and Judicial Retirement System of Texas (JRS).



## Retirement Systems

*This section will provide you with pertinent contact information*

**W**hen it comes to retirement, there are multiple possible sources of income for you. Below are the most common and most important as well as contact information.

### Texas County & District Retirement System (TCDRS)

- Defined as a 403(b) by the Internal Revenue Service (IRS)
- Contact member services at **1-800-823-7782** to obtain retirement estimates. Hours of operation are 7:30am to 6:00pm Monday through Friday.

### The Alternate Plan (Social Security replacement)

- Defined as a 457(b) by the Internal Revenue Service (IRS)
- Contact First Financial at **1-800-523-8422** to inquire about options and for account balances.

### Nationwide Retirement Solutions

- Nationwide offers voluntary retirement accounts for employees.
- Contact Scott Brooks at **1-409-370-2393**.

### Social Security

- If you have had employment elsewhere other than with Galveston County and have paid into Social Security you will need to make plans to account for the involvement of Social Security.
- The Social Security office in Angleton, Texas is better suited to guide you in regards to the County's unique retirement options and plans.
- 2921 North Valderas St, Angleton, Texas 77515. **1-866-338-2940**.



## TCDRS Pension

*This section will explain the key components of your pension plan*

**T**he main source of your retirement income as a retiree from Galveston County will be from the Texas County & District Retirement System (TCDRS). Although it is not the only retirement plan you have, it is the main one.

### Deposits & Vesting:

Throughout your employment with Galveston County, you have been depositing 7% of your gross earnings into your TCDRS account on a pre-tax basis. You also earn 7% interest annually on your account balance. Once you are vested and meet retirement eligibility, the County will match your account balance (principal plus interest) at 200%.

### Payments from TCDRS:

Your account balance, interest earned and the County match will be used by TCDRS to calculate your monthly pension payment.

Once you retire you will receive a monthly payment from TCDRS for the rest of your life. Your payment will be direct deposited into an account of your choosing on the last day of each month.

### Beneficiaries:

At the time of your retirement, you will have the opportunity to select various options regarding continued payments to your selected beneficiary. Your beneficiary(ies) will continue (depending on the option selected) to receive a monthly payment for the remainder of their life should you pass away first.

### Important Notes

- You will receive a 1099 form for income tax purposes at the end of the year
- Address and phone number changes must be submitted in writing
- IRS taxes is the only deduction withheld from TCDRS payment



# Service Retirement Application

TCDRS-22  
REV. 1/2015  
PAGE 1 OF 2

## Congratulations on your retirement!

Deciding to retire is one of the most important life decisions you will make and TCDRS is here to help you. TCDRS Member Services can help you make the decision that is best for you and your loved ones. Some of the topics you can discuss with TCDRS Member Services are:

- Do you need to provide income for someone else?
- What monthly benefit payment option is best for you?
- What retirement date is best for you?

You can estimate your monthly benefit payment and view the retirement planning information online at [www.tcdrs.org](http://www.tcdrs.org). You may want to run various benefit estimates so you have the knowledge to make the right retirement decision for you and your loved ones.

## Completing your retirement forms

Forms to complete for retirement:

- Retirement Application (TCDRS-22)
- Retirement Benefit Options (TCDRS-23)
- Direct Deposit Authorization (TCDRS-70)
- Income Tax Withholding (TCDRS-73)

Documents to submit with your application:

- Photocopy of your driver's license (or other government issued photo ID)
- Photocopy of your beneficiary's driver's license (or other government issued photo ID) if you select a Dual Life benefit payment option

Please have your employer certify this completed application. If you need another form to name additional beneficiaries in the beneficiary section of the Retirement Benefit Options (TCDRS-23) form, please visit the TCDRS website and download the Annuitant Beneficiary Designation form (TCDRS-85).

Once we receive your application, we will send you a confirmation within two weeks. You are able to change your benefit payment option until your first payment is issued.

## When to expect your first monthly benefit payment

Your benefit payments begin the last day of the month following your effective retirement date. For example, if your retirement date is March 31, 2015, your first monthly benefit payment will be issued by April 30, 2015.

## Other important information

- You must terminate your employment with the employer you are retiring from before your retirement date.
- You have until 6 months after your retirement date to submit your retirement application. If you submit your retirement application after your intended retirement date, you will receive retroactive payments from the intended retirement date.
- If you have more than one TCDRS account, you can make different elections for each account by submitting the appropriate separate forms.
- Please complete and return all pages of your retirement application and make sure all required signatures are on your application.

## Social Security Notice

The IRS and Texas law require that we have a Social Security number for every TCDRS account. Payments from your account, by withdrawal or retirement, are reported to the IRS. Your Social Security number is also used to verify your identity when you make changes to or request information about your account.

If you have questions, please visit [www.tcdrs.org](http://www.tcdrs.org) or call TCDRS Member Services at 800-823-7782.

Any corrections or whiteouts must be initialed.



# Service Retirement Application

## YOUR INFORMATION

EMPLOYER NAME *			ACCOUNT NUMBER	
Galveston County			183	
SSN *	FIRST NAME *	MIDDLE NAME	LAST NAME *	
MAILING ADDRESS *		CITY *	STATE *	ZIP *
EMAIL ADDRESS		HOME PHONE	MOBILE PHONE	

## TEXAS PUBLIC RETIREMENT SYSTEM ACCOUNTS

Do you have service with another retirement system to use toward qualifying for retirement?

Employees Retirement System of Texas (ERS)
  Teacher Retirement System of Texas (TRS)

Texas Municipal Retirement System (TMRS)
  Judicial Retirement System of Texas (JRS)

City of Austin Employees Retirement System (COAERS)

---

**Have you been employed with more than one county or district?** If so, please specify from which county/district you would like to retire, or select All Counties/Districts.

All Counties/Districts
  Specific County/District:

## YOUR CERTIFICATION

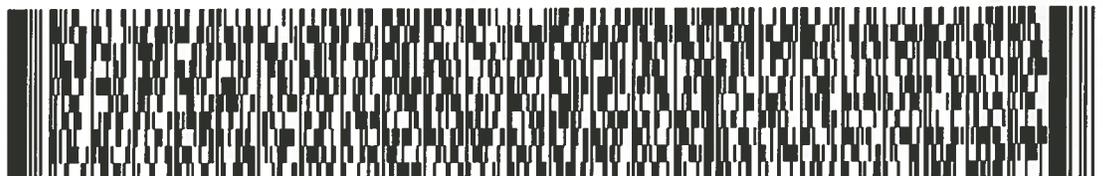
I understand my retirement will be canceled if I have a commitment from my current employer to be rehired. Additionally, I further understand my retirement will be canceled if I return to work for my current employer in the month following my retirement. I select the following retirement date:

MEMBER RETIREMENT DATE (MM/YYYY) *	
SIGNATURE	DATE
X	

## EMPLOYER CERTIFICATION

I verify that this employee is terminating employment with no arrangement or agreement to be rehired. Additionally, if this employee is rehired by this county/district and there is less than one full calendar month separation from employment, then the employee will be advised that his/her retirement is canceled. I also understand that by not following this separation from employment, my organization could lose its qualified plan status with the IRS and that will be extremely costly to my organization.

MEMBER TERMINATION DATE (MM/DD/YYYY) *		
EMPLOYER CONTACT NAME		EMPLOYER CONTACT TITLE
SIGNATURE	DATE	
X		



\* REQUIRED FIELDS

Any corrections or whiteouts must be initialed.



# Retirement Option Selection

## YOUR INFORMATION

SSN *	FIRST NAME *	MIDDLE NAME	LAST NAME *
-------	--------------	-------------	-------------

I hereby certify that  I do \*  I do not have a spouse at this time.\*

If you have more than one account, please designate which account this retirement applies to:

All Counties and Districts     Specific County/District:

## MONTHLY BENEFIT PAYMENT OPTIONS Please check only one option on this page.

All of the TCDRS benefit payment options provide you with a monthly payment for the rest of your life.

### SINGLE LIFE AND GUARANTEED TERM BENEFIT PAYMENT OPTIONS

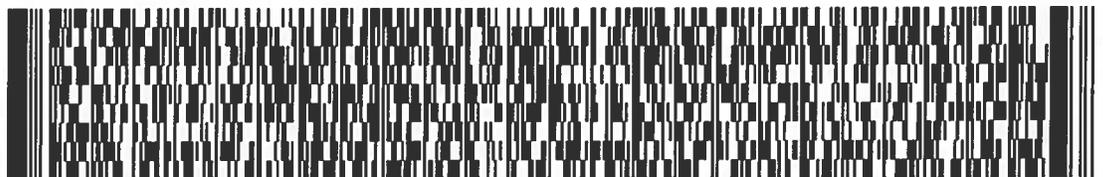
These options provide a lifetime income for you only and are solely based on your life expectancy. You may change your beneficiary at any time. Please complete the spousal consent section on page 2 if you are married.

- Single Life** This option provides the highest payment amount and all payments end after you pass away.
- 10-Year Guaranteed Term** Your beneficiary will get your monthly payment only if you pass away within 10 years of your retirement date.
- 15-Year Guaranteed Term** Your beneficiary will get your monthly payment only if you pass away within 15 years of your retirement date.

### DUAL LIFE BENEFIT PAYMENT OPTIONS

These options provide a lifetime income for both you and your beneficiary. Your primary beneficiary will continue to receive a percentage of your benefit for the rest of his or her life after you pass away. You cannot change your beneficiary.

- 50% to Beneficiary** Your beneficiary will receive 50% of your monthly payment after you pass away.
- 75% to Beneficiary** Your beneficiary will receive 75% of your monthly payment after you pass away.
- 100% to Beneficiary** Your beneficiary will receive 100% of your monthly payment after you pass away.
- 100% to Beneficiary with Pop-up** Your beneficiary will receive 100% of your monthly payment after you pass away. If your beneficiary dies before you, your monthly payment will pop up to the higher Single Life benefit amount.



\* REQUIRED FIELDS

Any corrections or whiteouts must be initialed.



# Retirement Option Selection

**PRIMARY BENEFICIARY** Unless otherwise specified, benefits will be divided equally among all persons listed as primary beneficiary. If you have selected a **Dual Life Option**, you can designate only one primary beneficiary.

SSN *	FIRST NAME *	MIDDLE NAME	LAST NAME *
DATE OF BIRTH *	GENDER * <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP TO YOU *	

SSN *	FIRST NAME *	MIDDLE NAME	LAST NAME *
DATE OF BIRTH *	GENDER * <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP TO YOU *	

SSN *	FIRST NAME *	MIDDLE NAME	LAST NAME *
DATE OF BIRTH *	GENDER * <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP TO YOU *	

**ALTERNATE BENEFICIARY** An alternate beneficiary receives your benefit if your primary beneficiary is not eligible.

SSN *	FIRST NAME *	MIDDLE NAME	LAST NAME *
DATE OF BIRTH *	GENDER * <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP TO YOU *	

SSN *	FIRST NAME *	MIDDLE NAME	LAST NAME *
DATE OF BIRTH *	GENDER * <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP TO YOU *	

To add additional beneficiaries or to designate a custodian for a minor, attach form TCDRS-95 ([www.tcdrs.org](http://www.tcdrs.org)).

**SPOUSAL CONSENT** If you are married, your spouse's consent must be obtained if your spouse is not your only primary beneficiary or if you name your spouse as beneficiary and have selected a Single Life or Guaranteed Term option.

I certify that I am the spouse of the member. I understand that I have the right to be named as the sole beneficiary under a benefit option that would pay me a benefit for my lifetime. Nonetheless, I hereby give up my right to a lifetime benefit and give my consent to the beneficiary designation and/or option selection shown on this form.

SPOUSE SIGNATURE X	DATE
-----------------------	------

## YOUR CERTIFICATION

I hereby select the form of retirement option shown by a check mark on page one of this form. I also revoke all previous beneficiary designations and request that any payments that may be due after my death be paid to the person(s) named above. Unless I have otherwise noted on this form, any amounts due upon my death will be paid equally to the surviving beneficiaries if more than one are named.

YOUR SIGNATURE X	DATE
---------------------	------



\* REQUIRED FIELDS

Any corrections or whiteouts must be initialed.



# Income Tax Withholding

## IMPORTANT NOTICE

This form lets you select the federal income tax withholding for your monthly benefit payment. If you choose not to have federal income tax withheld or if you don't have enough tax withheld, you may have to pay a tax penalty to the Internal Revenue Service (IRS). If you need help choosing a withholding amount, please talk to a professional tax advisor or contact the IRS at 800-829-1040 or [www.irs.gov](http://www.irs.gov). You may change your withholding amount at any time.

## YOUR INFORMATION

EMPLOYER NAME *			ACCOUNT NUMBER	
Galveston County			183	
SSN *	FIRST NAME *	MIDDLE NAME	LAST NAME *	
MAILING ADDRESS *		CITY *	STATE *	ZIP *
EMAIL ADDRESS		HOME PHONE	MOBILE PHONE	

## WITHHOLDING SELECTIONS (Please select ONE option below)

**OPTION 1:** Please withhold according to IRS withholding tables.

MARITAL STATUS:  MARRIED  SINGLE  MARRIED, but withhold at higher single rate.

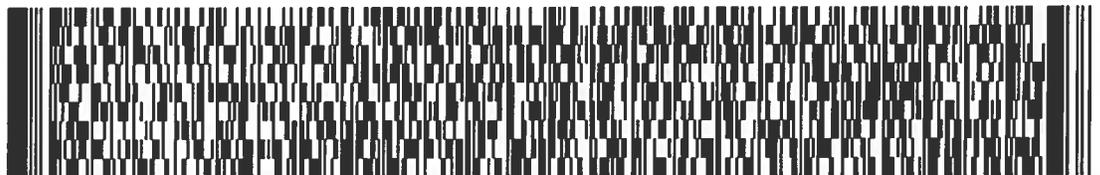
NUMBER OF PERSONAL EXEMPTIONS:

(OPTIONAL): Please withhold the following extra amount from each monthly payment:

**OPTION 2:** Do not withhold income tax from my monthly payment.

**YOUR CERTIFICATION** For the account referenced above, this form replaces any previous tax withholding instructions I have sent to TCDRS.

SIGNATURE	DATE
X	



\* REQUIRED FIELDS

Any corrections or whiteouts must be initialed.



# Direct Deposit Authorization

## NOTICE

This form must be received by the 15th of the month for your monthly benefit payment to be directly deposited into your bank account by the end of the month.

## YOUR INFORMATION

Galveston County			183	
FORMER EMPLOYER NAME *			ACCOUNT NUMBER	
FIRST NAME *	MIDDLE NAME	LAST NAME *	SSN *	
MAILING ADDRESS *		CITY *	STATE *	ZIP CODE *
E-MAIL ADDRESS		HOME PHONE NUMBER	MOBILE PHONE NUMBER	

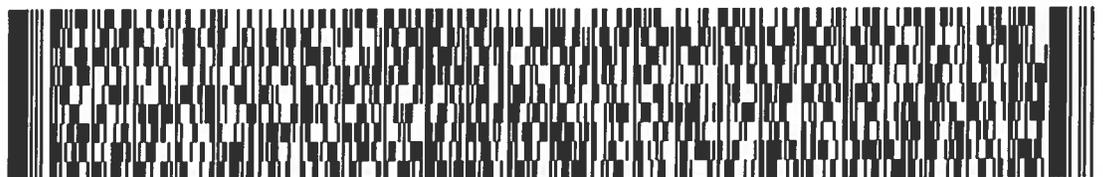
## BANKING INFORMATION

FINANCIAL INSTITUTION *		ROUTING NUMBER *	ACCOUNT NUMBER *	<input type="checkbox"/> CHECKING *
				<input type="checkbox"/> SAVINGS *
MAILING ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER				

**YOUR AUTHORIZATION** For the account referenced above, I authorize the Texas County & District Retirement System (TCDRS) to deposit my monthly benefit payments into my bank account. I also authorize TCDRS to make adjustments to my account to correct any transactions made in error. This authority shall remain in effect until I notify TCDRS to discontinue this payment method. I have requested the Texas County & District Retirement System to directly deposit my benefit payments by electronic transfer to the above referenced account and I hereby authorize the financial institution named above to disclose to the Texas County & District Retirement System at any time my address and contact information, and to disclose the names and addresses of all joint owners, signatories, beneficiaries or other persons associated with the above referenced account if I pass away. A photocopy of this signed form shall be sufficient authorization for such disclosure.

X SIGNATURE	DATE
-------------	------

\* REQUIRED FIELDS



Any corrections or whiteouts must be initialed.



## AUL Alternate Plan

*This section will explain the Social Security opt out plan*

Perhaps one of the most unique aspects about employment with Galveston County is the fact that in 1980 the County opted out of Social Security. This means that no employee of Galveston County pays Social Security taxes.

### The Alternate Plan

Although the County opted out of participation in Social Security, employees **must** still pay into a private plan that is similar to Social Security. The chosen plan is referred to as the Alternate Plan through American United Life (AUL) and is administered by First Financial.

- Employees contribute 6.13% of their gross salary on a pre-tax basis into an individual and private account.
- Galveston County contributes an additional 3.607% to your account.
- Your account balance is guaranteed to earn 3.75% interest annually if you leave your account in a fixed interest status. You may choose to invest your deposits in an array of different options. Please contact Kathy Trussell at **1-713-530-4054** to schedule a meeting and discuss your options.

### Available Options

Unlike TCDRS where you must take a lifetime monthly payment, with AUL you have many more options on what to do with your money. You can:

1. Withdrawal your entire account balance; or
2. Leave your account as is and withdrawal amounts as needed over time; or
3. Rollover your account into an IRA; or
4. Annuitize your account to receive a monthly payment.

### Important Note

Anytime you withdrawal money it is subject to 20% IRS withholding.







## Electronic Fund Transfer

Use this form to request: Installment payments or RLRP repetitive annuity payments to be sent directly to your bank account via electronic fund transfer.

American United Life Insurance Company<sup>®</sup>  
a ONEAMERICA<sup>®</sup> company  
One American Square, P.O. Box 368  
Indianapolis, IN 46206-0368  
1-800-249-6269



### A. Participant Information

Name: \_\_\_\_\_  
Plan Number: G74855 \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

SSN: \_\_\_\_\_  
Daytime Phone Number: (\_\_\_\_) \_\_\_\_\_  
Evening Phone Number: (\_\_\_\_) \_\_\_\_\_  
Evening Phone Number: (\_\_\_\_) \_\_\_\_\_

### B. Financial Institution Information

Please keep in mind that your first payment after establishing Electronic Fund Transfer (EFT) or changing your existing EFT information may be sent via paper check while we pre-note with your bank. Please allow 10 business days for your EFT information to be updated.

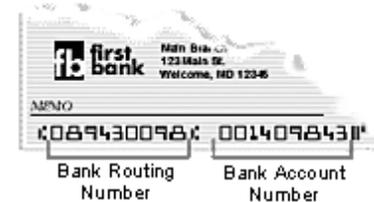
#### Financial Information – required information

- Checking Account  
 Savings Account

Bank Name: \_\_\_\_\_

Bank Routing (ABA) Number: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_



Routing Number must be 9 digits

Account Number cannot exceed 17 digits

Please attach a blank voided check copy for checking accounts or a deposit slip for savings accounts for verification of your account number.

\*Electronic Fund Transfer should only be used to send your installment and annuity payments to a bank account. Payments that are being rolled over to another carrier cannot be transferred electronically.

### C. Participant Certification

I authorize American United Life Insurance Company<sup>®</sup> (AUL) to deposit all contract payments due me into the account identified below by Electronic Fund Transfer. I discharge AUL from any further liability for any payments deposited to my account under this authorization. I also authorize AUL to initiate corrections, if necessary, to any amounts credited to my account in error. Any such payments shall be returned to AUL by the Financial Institution if funds are available in my account or shall be returned to AUL by my estate or my heirs if the funds in my account are not sufficient to make the required correction.

I understand that AUL may terminate its electronic fund transfer at any time and for any reason, and may make contract payments by check instead.

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Life Insurance Policy

*This section will explain the portability of your County life insurance policy*

**T**here are many things to account for during retirement. One of the most important things one can do for the care for a loved one after death is to have life insurance. Galveston County offers a life insurance policy, free of charge, to all benefit-eligible employees and retirees.

### Service Retirement:

Should you retire based on service, your county life insurance policy will convert to a **\$50,000** paid-up, guaranteed retired life reserve (RLR) policy that will remain with you for the rest of your life. You will receive a copy of the certificate of issuance upon retirement that lists the value of the policy and any beneficiaries you have listed. You may change your beneficiary at any time. There is no cash value to the retiree, only to the beneficiary.

### Disability Retirement:

Should your retirement be based on a qualifying disability, the current value of your life insurance policy will transport into retirement. The policy will not convert to \$50,000 as it does with a service retirement.

### Important Note

The county life insurance policy is a standard benefit offered to all benefit-eligible employees and is subject to change at the discretion of Commissioner's Court. The current policy value for employees is:

#### **Full-Time Employees**

- Under age 70: 4 x Annual Salary + \$15,000 (no less than \$75,000, no more than \$215,000)

#### **Half-Time/Part-Time Employees with Benefits**

- Under age 70: 2 x Annual Salary + \$15,000 (no less than \$37,500, no more than \$115,000)

#### **Benefits will be reduced at the following ages**

- Age 70 = Benefit reduced to 67%
- Age 75 = Benefit reduced to 43%

# DEFERRED COMPENSATION PLAN—PARTICIPANT'S TERMINATION REQUEST

Form #102G 01/02

<b>Name</b> <hr/>	Plan Sponsor (Employer) County of Galveston	Reason For Request <input checked="" type="checkbox"/> Termination or Retirement
<b>Street/ P.O. Box</b> <hr/>	Payroll Information 1. Final contribution is from payperiod ending _____ 2. Last date worked _____ 3. Final paydate is _____	<input type="checkbox"/> Long Term Disability <input type="checkbox"/> Death of Participant—attach certified death certificate(s) <input type="checkbox"/> Suspension of Participation Complete Sections I & II ONLY
<b>City/State</b> _____ <b>Zip</b> _____		
<b>Phone</b> _____ <b>Social Security #</b> _____		

**SECTION I-INVESTMENT INSTITUTIONS**

List all investment institutions:

Company \_\_\_\_\_ Account # \_\_\_\_\_

Company \_\_\_\_\_ Account # \_\_\_\_\_

Company \_\_\_\_\_ Account # \_\_\_\_\_

**SECTION II-NOTICE OF SUSPENSION**

Type of Suspension:  FULL  ADDITIONAL ONLY

Suspension is effective as indicated above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Approved by \_\_\_\_\_ Date \_\_\_\_\_

**SECTION III-DEFERRED COMPENSATION DISBURSEMENT PLAN**

**SELECT ONE OF THE FOLLOWING:**

I elect to defer receiving payment of the following Deferred Compensation Plan Funds. I understand that I must begin distribution by Age 70½.

\_\_\_\_\_

I elect to begin distribution of certain Deferred Compensation Plan funds effective upon separation of service. \*\*My chosen method of payment is as follows:

Lump Sum (attach P-10608F)  Annuity Option (attach P-6882U, W-4)

Direct Rollover \_\_\_\_\_

Other, specify \_\_\_\_\_

**SECTION IV-GROUP POLICY CONVERSION ELECTION**

I elect the following option concerning my Group Term Life insurance policy:

No conversion of the Group Policy. I understand that this coverage will lapse 31 days after last date worked.

Conversion of Group Policy coverage to an individual policy of life insurance. I understand that I must submit all conversion forms and my check for the premium amount due not later than 31 days after my last date worked. (CONTACT PLAN ADMINISTRATOR PROMPTLY)

Waiver of Premium Option due to "TOTAL DISABILITY", since I am age 59 or younger. I acknowledge receipt of Application for Disability claim forms.

Retired Lives Reserves (RLR) coverage in the amount of \$ 50,000.00

My hire date was \_\_\_\_\_ and my birthdate is \_\_\_\_\_

**SECTION V-ACKNOWLEDGMENT AND AUTHORIZATION**

I acknowledge that this request is subject to approval by my Plan Sponsor and that a full explanation of benefits has been provided to me. I authorize my Plan Sponsor and the Plan Administrator to process this withdrawal request as completed. I fully understand that any distribution of funds must be reported as income in the year received.

**PARTICIPANT'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

APPROVAL BY \_\_\_\_\_ **DATE** \_\_\_\_\_

Deferred Compensation Plan Administrative Committee

\* There is a penalty for lump sum withdrawals. Penalties are waived under annuity payout options.  
 \*\* No distribution of funds may begin until your last payroll deduction has been received and allocated into your Plan account(s).



## Medical Coverage

*This section will explain your medical coverage throughout retirement*

**T**he need for medical insurance is perhaps more important during retirement than it is during any period of your life. As you age, your health will be a top concern for you. As a retiree from Galveston County you will have the option to carry your medical coverage with you into retirement.

### Retirement before age 65:

Should you retire before the age of 65 you will be allowed to retire with your current level of coverage. You cannot add any products or change coverage at the time of retirement, you can only decrease coverage and once you decrease coverage, you can never increase it in the future. You will continue to pay your current premiums.

### Medicare at age 65:

As a retiree of Galveston County, the month that you turn 65 years of age, you will be automatically switched to a Medicare supplement plan through Boon-Chapman and you will need to enroll in **Medicare parts A & B**. Do not enroll in Medicare part D because you will continue to use the plan offered by the County. If you are already 65 years old or older at the time that you retire, you will be switched to the Medicare supplement at the time of your retirement.

### Payment of Premiums:

At the time that you retire, you will provide Human Resources with the bank account information you wish to pay your monthly premiums with. The Galveston County Treasurer's office has anywhere from **between the 1<sup>st</sup> and the 10<sup>th</sup> of each month** to draft your premium payment.

**Boon-Chapman Benefit Status Form for Retirees**  
**County of Galveston**

Employee       Male       New Enrollment       Add       Medical       Dental       Vision  
 Retiree       Female       Change       Drop

<b>OFFICE USE ONLY:</b> Employee Hire Date: _____ Dept #: _____ Job Title: _____			FT <input type="checkbox"/> HT <input type="checkbox"/>
Employee/Retiree - Last Name      First      M.I.		Date of Birth	Social Security # / Employee ID
Mailing Address		Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/>	Home/Cell Phone (      ) (      )
City	State	Zip Code	

<b>Medical Coverage Election</b>	<b>OFFICE USE ONLY:</b> Employee Effective/Term Date: _____ Premium: \$ _____				
A. I elect the following Medical Plan: <input type="checkbox"/> HDHP <input type="checkbox"/> Base Plan <input type="checkbox"/> Buy-Up Plan <input type="checkbox"/> Retiree/Medicare Supplement <input type="checkbox"/> CareHere (\$25/month if Medicare Supp.)					
B. I would like to enroll the following: <input type="checkbox"/> Myself Only <input type="checkbox"/> Myself & Spouse <input type="checkbox"/> Myself & Child(ren) <input type="checkbox"/> Myself & Family					
<b>Dependent:</b> Last Name      First      M.I.	Social Security #	Birth Date	Relationship	Effect Date	Term Date

<b>Dental Coverage Election</b>	<b>OFFICE USE ONLY:</b> Employee Effective/Term Date: _____ Premium: \$ _____				
I would like to enroll the following for Dental: <input type="checkbox"/> Low Plan <input type="checkbox"/> High Plan <input type="checkbox"/> Myself Only <input type="checkbox"/> Myself & Spouse <input type="checkbox"/> Myself & Child(ren) <input type="checkbox"/> Myself & Family					
<b>Dependent:</b> Last Name      First      M.I.	Social Security #	Birth Date	Relationship	Effect Date	Term Date

<b>Vision Coverage Election</b>	<b>OFFICE USE ONLY:</b> Employee Effective/Term Date: _____ Premium: \$ _____				
I would like to enroll the following for Vision: <input type="checkbox"/> Vision Plan <input type="checkbox"/> Myself Only <input type="checkbox"/> Myself & Spouse <input type="checkbox"/> Myself & Child(ren) <input type="checkbox"/> Myself & Family					
<b>Dependent:</b> Last Name      First      M.I.	Social Security #	Birth Date	Relationship	Effect Date	Term Date

**Medical Waiver Verification - If Declining Coverage**

I certify that I have been offered group medical coverage by the County, but am opting out at this time. I acknowledge that stricter enrollment and/or pre-existing condition limitations may apply should I later wish to enroll for this coverage.

I am currently covered under another medical plan\*\*.....OR..... Other: (Please explain.) \_\_\_\_\_

\*\*If you are declining the medical plan due to other medical coverage, please provide the following information:

Name & Phone Number of other Insurance Company: \_\_\_\_\_

Name of the Employer or Group providing the Plan: \_\_\_\_\_ Name of Person(s) covered under this Plan: \_\_\_\_\_

**Coordination of Benefits for Medical/Dental/Vision - If Covered by Another Plan**

- 1. Are you or your dependents covered under any other group plan?  Yes  No
- 2. Are you or your dependents covered under any Federal, State, or government plan (Including Medicare/Medicaid)?  Yes  No
- 3. Does the other group plan have coordination of benefits?  Yes  No
- 4. Is there a divorce order stating who is **responsible** for coverage for dependents?  Yes  No If "Yes" Name of Responsible Party \_\_\_\_\_

If "Yes" to any of the above questions, please provide the following information:

Name & Phone Number of other Insurance Company: \_\_\_\_\_

Name of the Employer or Group providing the Plan: \_\_\_\_\_ Name of Person covered under this Plan: \_\_\_\_\_

**Definition of Eligible Dependent for Medical/Dental/Vision Plans**

Eligible dependents include your lawful spouse as defined by applicable state law, natural child, stepchild, adopted child, foster child, and child for whom you are legal guardian, managing conservator, joint managing conservator or possessory conservator who has a duty to provide coverage for a dependent child (a **certified copy of court order appointing you as one of the above must be submitted along with this application**). Dependents of retiree's may also participate if they were covered under the plan prior to retirement. Dependent child remains eligible until age 26, regardless of student or tax dependency status, unless he/she is eligible for other coverage through and employer-based health plan. (other than that of his/her parents), regardless of his/her participation in the other plan.

**Please Read, Sign, and Date**

**If I have selected dependent coverage, I hereby authorize my employer to deduct the applicable cost of premiums. I also certify that the dependent(s) listed above are legal dependents as described in the County of Galveston's Health Protection Plan and understand that any misrepresentation is cause for disciplinary action up to and including termination of my employment, termination of coverage, nonpayment of benefits, and recovery of any claims that have been paid.**

Signature of Employee/Retiree: \_\_\_\_\_

Date: \_\_\_\_\_

Original – Human Resources Department    Copy – Employee/Retiree    Copy – Auditor    Copy – Boon-Chapman



**GALVESTON COUNTY TREASURER'S OFFICE**

722 Moody Ave 4<sup>th</sup> Floor, Galveston, TX. 77550  
Phone: 409-770-5428 Fax: 409-765-3246

**HEALTH INSURANCE PAYMENT AUTHORIZATION**

**Name:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

\_\_\_\_\_  
**City**

\_\_\_\_\_  
**State**

\_\_\_\_\_  
**Zip Code**

\_\_\_\_\_  
**Social Security Number**

\_\_\_\_\_  
**Date of Birth**

I request and authorize Galveston County Treasurer's Office to initiate debit entries to my:  
**(Select one of the following)**

\_\_\_\_\_  Checking Account

\_\_\_\_\_  Savings Account

\_\_\_\_\_  Credit Card

This request and authorization applies to:  
**(please check all that apply)**

\_\_\_\_\_  Health Care Premium

\_\_\_\_\_  CareHere Monthly Premium

\_\_\_\_\_  CareHere No-Show Fee

\_\_\_\_\_  Other

**Name on Bank Account** \_\_\_\_\_

**Bank/Credit Union Name** \_\_\_\_\_

\_\_\_\_\_  
**Routing Number**

\_\_\_\_\_  
**Account Number**

\_\_\_\_\_  
**City**

\_\_\_\_\_  
**State**

\_\_\_\_\_  
**Zip Code**

**Name on Credit Card** \_\_\_\_\_

\_\_\_\_\_  
**Type of Credit Card**

\_\_\_\_\_  
**Credit Card Number**

\_\_\_\_\_  
**Expiration Date**

**The County Treasurer is authorized to impose a fee of \$30.00 of all returned items for services rendered by Galveston County as allowed in the Local Government Code Sec.118.142**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

**THIS AUTHORIZATION IS TO REMAIN IN FULL FORCE AND EFFECT UNTIL GALVESTON COUNTY HAS RECEIVED WRITTEN NOTICE OR A VIOLATION OF INSURANCE TERMS AND POLICY.**



## Other Optional Benefits

*This section will explain how to maintain your other benefits during retirement*

**B**oon-Chapman products are generally considered the only plans that you can continue to maintain throughout retirement and that Galveston County will assist you with. However, that doesn't mean you have to drop your other coverage.

### First Financial:

First Financial Group of America is the administrator of most of the other products offered to you during your employment with Galveston County. If you are enrolled in any products administered by FFGA please contact them directly to inquire about the possibility of keeping your plan(s) into retirement:

First Financial Group of America  
PO Box 670329  
Houston, TX 77267-0329  
Phone: 1-800-523-8422  
[www.ffga.com](http://www.ffga.com)

### Aflac:

If you are enrolled in any of the Aflac products that are offered through the County please contact Barbara Meeks at **281-236-3566** or [Meeksbarbara@aol.com](mailto:Meeksbarbara@aol.com) and she will assist you with an individual billing plan that will allow you to continue your coverage.

### Employee Assistance Program (EAP):

You can elect to keep your enrollment with EAP active as a retiree. The premium for this coverage is very minimal at just \$1.85 per month (\$22.20/year). This premium can be added to your monthly bank draft or you can elect to pay it directly to the Treasurer's office.

## Employee Assistance Program Enrollment Form Galveston County

EAP provides confidential counseling assistance for members or their dependents dealing with problems such as marital or family discord, drug or alcohol dependency and legal assistance. The member receives six (6) free visits per year. The program is designed to help you and your dependents successfully manage life's challenges by identifying options and making informed choices.

The monthly premium for the program is \$1.85 (\$22.20/year).

List eligible persons to be covered: (Persons previously covered only)

Name	Birthdate	Sex	Relationship	Social Security #
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I hereby request enrollment in the plan for myself and eligible dependents listed on this form and agree to pay the premium as required.

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Opt-out:**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Final Check & Payouts

*This section will explain what to expect with your final paycheck from the County*

**Y**our final paycheck from the County will be direct deposited into your bank account as it normally is as long as you have no outstanding County property in your possession. Your final check will include wages owed for the final pay period in which you worked along with any payouts that you may be entitled to.

### Final Check:

Your final check will include any time worked in the pay period immediately preceding your retirement date. Retirements are always effective the last day of the month in which you retire. Your final check will also include any payouts for unused sick and vacation leave you may be entitled to. Limits on payouts are outlined below. In order to avoid potentially high taxes on your payouts, you may elect to rollover the payout amount into a voluntary retirement account.

### Payout of Unused Vacation leave:

Employees hired prior to October 1, 2011 are paid accumulated vacation leave up to the maximum permitted amount upon retirement from County.

Employees hired on or after October 1, 2011 are paid a maximum accumulated vacation leave up to 120 hours of accumulated leave upon retirement from the County.

### Payout of Unused Sick Leave:

Active employees eligible for regular service retirement or disability retirement who were hired before October 1, 2011 and retire under that system of TCDRS or AUL are paid one-half awarded unused sick leave upon retirement from the County.

Active employees who were hired on or after October 1, 2011, who are eligible for regular service retirement or disability retirement and retire under that system of TCDRS or AUL are not paid for unused sick leave upon retirement from the County.





**For Human Resources Use Only  
Check List for Retirement**

**Employee Name:** \_\_\_\_\_

**Street:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**W-2 Forms**

Provide Human Resources Department with your correct address and phone number(s) to receive your W-2 Form in January.

**Type of Retirement:**

Service       Disability

**Effective Date of Retirement:** \_\_\_\_\_

**Texas County and District Retirement System – 1-800-823-7782 / (512) 328-8889**

- You will receive a 1099 form for income tax purposes at the end of the year.
- An employee must have a payroll deposit going into the retirement system every month up until the date of the effective retirement. If there is no deposit for any given month, the retirement date will change accordingly.
- IRS taxes is the only deduction from check unless waived

- Deferred Retirement (Eligible to retire, but does not want to start annuity payments)
- Form 41 – Estimate Request
- Form 22 - Application For Service Retirement
- Form 23 – Retirement Option Selection and Retirement Beneficiary Designation - (Same Form)
- Form 73 – Income Tax Withholding Form
- Form 70 – Direct Deposit
- Copy of Drivers License - Member
- Copy of Drivers License - Beneficiary
- Form 31 – Disability Retirement Application
- Form 32 – Physician’s Statement on Disability / Total amount of Physician’s Statements \_\_\_\_\_
- Form 33 – Member’s Statement on Disability

**First Financial- 1-800-523-8422 / (281) 847-8429**

- Retirement Options (AUL account / Voluntary account(s))
- Certificate of coverage under County of Galveston issued by Standard Life Insurance
- Texas Life refund (if entitled)
- Premium payments for Cancer Plans, Humana Vision/Dental/Life Insurance, Standard Life Insurance
- Flexible Spending or Dependent Care FSA Accounts

- RLR Form (Requirements: minimum of 8 years of service to Galveston County & approved for a TCDRS retirement)
- AUL Distribution Form
- AUL Electronic Fund Transfer Form
- AUL Annuity Request Form

The Commissioners' Court will review benefit plans for all employees and retirees annually. After this review, benefits can be changed or terminated for employees and/or retirees.

**You cannot add any dependents or increase any of your benefits at, or after, time of retirement. You can only continue coverage of what is already in place.**

**Are you going to a new employer that offers medical coverage that you would be eligible for?**  Yes  No

**If so, please provide name of Insurance Company:** \_\_\_\_\_

- Boon-Chapman Retiree Benefit Status Form
- COBRA Notice for First Financial products
- Employee Assistance Program Form
- Treasurer's ACH Form (Premiums will be drafted between the 1<sup>st</sup> and the 10<sup>th</sup> of each month)
- Deferred Payouts form
- Nationwide Retirement Solutions Benefit Options form- (877) 677-3678

**PAYROLL CHECK**

*Vacation and sick hours will be paid according to County Policy and will be on the final check.*

Date of final payroll check: \_\_\_\_\_

\_\_\_\_\_  
**Employee Signature** **Date:** \_\_\_\_\_

\_\_\_\_\_  
**Human Resources Assistant** **Date:** \_\_\_\_\_