



SUFFOLK COUNTY
NEW YORK
Deferred Compensation Plan

Steve Randazzo
Chair
Assistant Deputy County Executive

Jeffrey Cergol
Vice Chair
Detectives Association

Kristine Sciangula
Plan Administrator
Human Resources, Personnel & Civil Service

Linda Brown
Treasurer
Association of Municipal Employees

Tom Bivona
Deputy Sheriffs PBA

Christina Blake
Administrator IV

Dennis Brown
Director of Real Property Tax Service

Edward Fennessey
Detective Investigators Association

Donald Grauer
Probation Officers Association

Debra Kolyer
Chief Financial Analyst

Michael Koubek
Superior Officers Association

Deirdre Lepore
Director of Payroll Services

Maria Nida
Legal Advisor
Senior Assistant County Attorney

Michael Simonelli
Police Benevolent Association

Robert Smith
Principal Programmer Analyst

Gregory Spicer
Principal Assistant County Attorney

Robert Varrichio
Correction Officers Association

Stefanie Ennis
Secretary to the Board
Assistant to Personnel Officer

Plan Provider
T. Rowe Price
1-888-457-5770
www.rps.troweprice.com

Dear Participant:

Attached please find the Public Safety Officer Qualified Health Insurance Premium Payment Authorization Form ("Form").

Due to a legislative change on the federal level, government deferred compensation plans can include a provision that benefits retired public safety officers (PSOs). On May 28, 2008, the Suffolk County Public Employees Deferred Compensation Board adopted this provision by amending its Suffolk County 457 deferred compensation plan ("Plan"). The Plan permits eligible PSOs who, by reason of disability or attainment of normal retirement age, are separated from service as public safety officers with an employer who maintains the eligible retirement plan to withdraw up to \$3,000 annually from the Plan, free from income tax, to pay for qualified health insurance premiums for accident, health, or long term care for themselves, their spouses or dependents. The amount distributed must be paid directly from the Plan to the insurance provider and must not exceed the amount paid by the participant for such qualified health insurance premiums for the tax year.

Please attach a copy of the premium notice to the Form and follow the instructions for submitting the Form. The funds will be withdrawn from the Plan pro-rata, that is, proportionally from each of your investments. For example, assume that 70% of your money is in Investment A and 30% is in Investment B, and you elect to transfer \$3,000 to your insurance carrier. That means \$2,100 would come from Investment A and \$900 would come from Investment B. Some mutual funds may impose a short-term trading fee. Please read the underlying prospectuses carefully.

The withdrawal will be forwarded to your insurance carrier via hard check.

Please note by signing and submitting the request, you are certifying that you are an eligible public safety officer under the Internal Revenue Code Section 402(l) and the rules, regulations and guidance issued thereunder, and that the payment is being remitted for qualified health insurance premiums. Not all insurance plans qualify for this distribution. Distributions made to pay for unqualified participants and/or unqualified insurance premiums may be subject to income tax liabilities and penalties. Consult your professional tax advisor prior to completing this Form to determine if you and your insurance plan qualify.

Very truly yours,

Suffolk County Public Employees Deferred Compensation Board

c/o Human Resources, Personnel & Civil Service, Bldg. 158, PO Box 6100, Hauppauge, NY 11788
www.scddeferredcomp.org

**Suffolk County Public Employees Deferred Compensation Plan
Retired Public Safety Officer Qualified Health Insurance Premium
Payment Authorization Form**

Participant Information

Name Social Security Number

Street Address

City, State, ZIP Code

Daytime Phone Number Evening Phone Number Date of Birth

Distribution Method

I request that the amount be withdrawn from the Plan (check one*):

Pro-Rata Specific Investment _____
(Name of Investment)

(*amount will automatically be withdrawn pro-rata if section is not complete and in good order)

Pursuant to the enclosed Health Insurance premium notice, I hereby authorize the withdrawal of:

\$ _____ to the following insurance carrier. Premium Due Date _____

Insurance Carrier: _____

Insurance Policy #: _____

Name of Insured: _____

Insurance Company Mailing Address: _____

City, State, ZIP Code: _____

A copy of the insurance premium notice must be included with this form. Your request will be delayed if you do not include a copy of the premium notice. We must receive this form and a copy of the insurance premium notice no later than 15 days prior to the premium due date.

Participant's Authorization and Certification

I hereby authorize the Plan's trustee to pay the Health Insurance premiums directly to my insurance carrier. I understand that these premiums will be paid directly to the carrier (subject to a \$3,000 per year limitation) and will not be payable to me. I certify that I am an eligible public safety officer who, by reason of disability or attainment of normal retirement age, is separated from service as a public safety officer with the County of Suffolk. I further certify that the health insurance premiums qualify to be paid directly to the insurance carrier.

I understand that funds will be sold (based on the Distribution Method chosen) from my Plan account to pay this premium. If no Distribution Method is chosen, the funds will be sold pro-rata. Some mutual funds may impose a short-term trading fee. Please read the underlying prospectuses of the funds carefully.

I understand that I may be subject to civil and criminal liability for any and all false statements I have provided on this form or any papers attached to or related to this form.

Participant's Signature Date

Return to: T. Rowe Price Retirement Plan Services, Inc.
Special Attn.: Forms Enclosed
P.O. Box 17215
Baltimore, MD 21297-1215

