GROUP BENEFITS

GROUP RETIREE INSURANCE PLAN SUMMARY OF COVERAGE

THE HARTFORD

PREMIER 10 PLAN

UNDERWRITTEN BY: HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Calendar Year Deductible: $0 **[!]Calendar Year Out of Pocket Maximum: $500**

PART A SERVICES

SERVICES	MEDICARE PAYS[(1)]	PLAN PAYS[(1)]	YOU PAY
HOSPITALIZATION [(2)] Semi-private room and board, general nursing, and miscellaneous services and supplies:			
First 60 days	All but the Part A Deductible	100% of Medicare Part A Deductible	**$0**
61st through 90th day	All but 25% of Medicare Part A Deductible per day	100% of Medicare Part A Coinsurance	**$0**
91st through 150th day (60 day Lifetime Reserve Period)	All but 50% of Medicare Part A Deductible per day	100% of Medicare Part A Coinsurance	**$0**
Once Lifetime Reserve days are used (or would have ended if used) additional 365 days of confinement per person per lifetime	$0	100%	**$0**
SKILLED NURSING FACILITY CARE Semi-private room and board, skilled nursing and rehabilitative services and other services and supplies. You must meet Medicare's requirement which includes hospitalization of at least 3 days. You must enter a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	**$0**
21st through 100th day	All but 12.5% of Medicare Part A Deductible per day	Up to 100% of Medicare SNF Coinsurance	**$0**
101st through 365 day	$0	$0	**All other charges**

THE HARTFORD

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
BLOOD DEDUCTIBLE – **Hospital Confinement and Out-Patient Medical Expenses** When furnished by a hospital or skilled nursing facility during a covered stay.			
First 3 pints Additional amounts	$0 100%	100% $0	**$0** **$0**
HOSPICE CARE Pain relief, symptom management and support services for terminally ill.			
As long as Physician certifies the need	All costs, but limited to costs for out-patient drug and in-patient respite care	Co-insurance charges for in-patient respite care, drugs and biologicals approved by Medicare	**All other charges**

PART B SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
OUT-PATIENT MEDICAL EXPENSES **The Policy may cover the following Medicare Part B Benefits:** • *Physician Services Benefit* • *Specialist Services Benefit* • *Outpatient Hospital Services and Ambulatory Surgical Care Benefit* • *Outpatient Diagnostic and Radiology Services Benefit* • *Outpatient Mental Health and Substance Abuse Services Benefit* • *Outpatient Rehabilitative and Cardiac Rehabilitative Services Benefit* • *Emergency Care Benefit* • *Urgent Care Benefit* • *Ambulance Services Benefit* • *Durable Medical Equipment and Prosthetics Benefit* *All Medicare Part B Benefits are based on per vist, except Ambulance Services Benefit, which is based on per trip, and Durable Medical Equipment and Prosthetics Benefit, which is based on per device.*			
Medicare Part B Deductible	$0	$0	**100%**
Remainder of Medicare-approved amounts	80%	100% of the remaining Medicare Part B Coinsurance after member copay	**$10 copay for all services except Emergency Care Benefit, which is a $50 copay**

THE HARTFORD

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
Part B Excess Charges for Non-Participating Medicare providers covers the difference between the 115% Medicare limiting fee and the Medicare-approved Part B charge	$0	100%	**$0**

ADDITIONAL SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
PREVENTIVE MEDICAL CARE & CANCER SCREENINGS[3] Coverage for expenses incurred by a covered person for physical exams, preventive screening tests and services, cancer screenings, and any other tests or preventive measures determined to be appropriate by the attending Physician. Refer to your Medicare and You handbook for more information on Preventive services.			
"Welcome to Medicare" Physical Exam -within first 12 months of Part B enrollment	100%	$0	**$0**
Annual Wellness Visit	100%	$0	**$0**
Vaccinations	100%	$0	**$0**
Preventive Care Cancer Screening Benefits[3]	Generally 100% for most preventive screenings. Some screenings subject to the Medicare Part B Deductible and Coinsurance	100% of remaining covered expenses Incurred not covered by Medicare	**$0**
FOREIGN TRAVEL EMERGENCY Medically necessary emergency care services.			

GROUP RETIREE INSURANCE PLAN
SUMMARY OF COVERAGE FOR PREMIER 10 PLAN

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
Emergency services needed due to Injury or Sickness of sudden and unexpected onset during the first 60 days while traveling outside the United States.	$0	80% after $250 Deductible (to a lifetime maximum of $50,000)	**$250 Deductible and then 20% of expenses incurred** (to a lifetime maximum of $50,000, then 100% thereafter)

! The Calendar Year Out of Pocket (OOP) Maximum applies to Medicare Part B Services. The plan pays the remaining coinsurance, if any, after your copayment, if applicable, until your OOP maximum has been met, then the plan pays 100%.

[1] This chart describes coverage that is only available to persons who are at least 65 and Medicare-eligible. Medicare amounts typically change January 1 of each year.

[2] A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Hospital does not include any institution or part thereof that is used primarily as a nursing home, convalescent home, or Skilled Nursing Facility; a place for rest, custodial, educational or rehabilitory care; a place for the aged; or, a place for alcoholism or drug addiction.

[3] If any of the cancer screening tests are not covered by Medicare, the plan will pay the usual and customary charges incurred. Please refer to your certificate for a full description of preventive screenings.

Please note this policy also may cover certain benefits mandated by the state where the employer is sitused or the state where you reside. Refer to your certificate for a description of any additional benefits.

Limitations & Exclusions: The Hartford's Insurance Plan does not cover any expense that is not a Medicare Eligible Expense or beyond the limits imposed by Medicare for such expenses or excluded by name or specific description by Medicare, except as specifically provided in the policy. The plan does not cover: Any part of a covered expense to the extent paid by Medicare; benefits payable under one benefit of the policy to the extent covered under another benefit of the policy; or expense incurred after coverage terminates, except as stated in the Extension-of-Benefits provision of the policy.

GROUP BENEFITS

GROUP RETIREE INSURANCE PLAN SUMMARY OF COVERAGE

THE HARTFORD

PREMIUM PLUS PLAN

UNDERWRITTEN BY: HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Calendar Year Deductible: $0 **Lifetime Maximum: Unlimited**

PART A SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
HOSPITALIZATION [2] Semi-private room and board, general nursing, and miscellaneous services and supplies:			
First 60 days	All but the Part A Deductible	100% of Medicare Part A Deductible	**$0**
61st through 90th day	All but 25% of Medicare Part A Deductible per day	100% of Medicare Part A Coinsurance	**$0**
91st through 150th day (60 day Lifetime Reserve Period)	All but 50% of Medicare Part A Deductible per day	100% of Medicare Part A Coinsurance	**$0**
Once Lifetime Reserve days are used (or would have ended if used) additional 365 days of confinement per person per lifetime	$0	100%	**$0**
SKILLED NURSING FACILITY CARE Semi-private room and board, skilled nursing and rehabilitative services and other services and supplies. You must meet Medicare's requirement which includes hospitalization of at least 3 days. You must enter a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	**$0**
21st through 100th day	All but 12.5% of Medicare Part A Deductible per day	Up to 100% of Medicare SNF Coinsurance	**$0**
101st through 365 day	$0	$0	**All other charges**

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
BLOOD DEDUCTIBLE – **Hospital Confinement and Out-Patient Medical Expenses** When furnished by a hospital or skilled nursing facility during a covered stay.			
First 3 pints Additional amounts	$0 100%	100% $0	**$0** **$0**
HOSPICE CARE Pain relief, symptom management and support services for terminally ill.			
As long as Physician certifies the need	All costs, but limited to costs for out-patient drug and in-patient respite care	Co-insurance charges for in-patient respite care, drugs and biologicals approved by Medicare	**All other charges**

PART B SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
OUT-PATIENT MEDICAL EXPENSES **The Policy may cover the following Medicare Part B Benefits:** • *Physician Services Benefit* • *Specialist Services Benefit* • *Outpatient Hospital Services and Ambulatory Surgical Care Benefit* • *Outpatient Diagnostic and Radiology Services Benefit* • *Outpatient Mental Health and Substance Abuse Services Benefit* • *Outpatient Rehabilitative and Cardiac Rehabilitative Services Benefit* • *Emergency Care Benefit* • *Urgent Care Benefit* • *Ambulance Services Benefit* • *Durable Medical Equipment and Prosthetics Benefit* *All Medicare Part B Benefits are based on per vist, except Ambulance Services Benefit, which is based on per trip, and Durable Medical Equipment and Prosthetics Benefit, which is based on per device.*			
Medicare Part B Deductible	$0	100% of Medicare Part B Deductible	**$0**
Remainder of Medicare-approved amounts	80%	100% of the remaining Medicare Part B Coinsurance	**$0**

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
Part B Excess Charges for Non-Participating Medicare providers covers the difference between the 115% Medicare limiting fee and the Medicare-approved Part B charge	$0	100%	**$0**

ADDITIONAL SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
PREVENTIVE MEDICAL CARE & CANCER SCREENINGS[3] Coverage for expenses incurred by a covered person for physical exams, preventive screening tests and services, cancer screenings, and any other tests or preventive measures determined to be appropriate by the attending Physician. Refer to your Medicare and You handbook for more information on Preventive services.			
"Welcome to Medicare" Physical Exam -within first 12 months of Part B enrollment	100%	$0	**$0**
Annual Wellness Visit	100%	$0	**$0**
Vaccinations	100%	$0	**$0**
Preventive Care Cancer Screening Benefits[3]	Generally 100% for most preventive screenings. Some screenings subject to the Medicare Part B Deductible and Coinsurance	100% of remaining covered expenses Incurred not covered by Medicare	**$0**
FOREIGN TRAVEL EMERGENCY Medically necessary emergency care services.			
Emergency services needed due to Injury or Sickness of sudden and unexpected onset during the first 60 days while traveling outside the United States.	$0	80% after $250 Deductible (to a lifetime maximum of $50,000)	**$250 Deductible and then 20% of expenses incurred** (to a lifetime maximum of $50,000, then 100% thereafter)

GROUP RETIREE INSURANCE PLAN
SUMMARY OF COVERAGE FOR PREMIUM PLUS PLAN

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
PRIVATE DUTY NURSING Service provided to a person while covered under this benefit and charged directly to the covered person by the nurse and not the hospital			
Up to a maximum of 3 shifts per day consisting of at least 3 consecutive hours of nursing care per shift	$0	100% of remaining covered expenses incurred after the copayment for 30 shifts per calendar year up to the benefit maximum of $500 per calendar year	**$20 copay per shift** (to a calendar year maximum of $500, then 100% thereafter)

[1] This chart describes coverage that is only available to persons who are at least 65 and Medicare-eligible. Medicare amounts typically change January 1 of each year.

[2] A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Hospital does not include any institution or part thereof that is used primarily as a nursing home, convalescent home, or Skilled Nursing Facility; a place for rest, custodial, educational or rehabilitory care; a place for the aged; or, a place for alcoholism or drug addiction.

[3] If any of the cancer screening tests are not covered by Medicare, the plan will pay the usual and customary charges incurred. Please refer to your certificate for a full description of preventive screenings.

Please note this policy also may cover certain benefits mandated by the state where the employer is situsedor the state where you reside. Refer to your certificate for a description of any additional benefits.

Limitations & Exclusions: The Hartford's Insurance Plan does not cover any expense that is not a Medicare Eligible Expense or beyond the limits imposed by Medicare for such expenses or excluded by name or specific description by Medicare, except as specifically provided in the policy. The plan does not cover: Any part of a covered expense to the extent paid by Medicare; benefits payable under one benefit of the policy to the extent covered under another benefit of the policy; or expense incurred after coverage terminates, except as stated in the Extension-of-Benefits provision of the policy.

Frequently Asked Questions

1. **Do the Retiree Medical Insurance Plans sponsored by Philadelphia Fire Fighter's Union Local 22 cover pre-existing conditions?**
   Yes. If the covered person replaced a prior medical policy immediately prior to the coverage under The Hartford's plan and provides proof of coverage under such prior policy, The Hartford will waive the pre-existing condition limitation to the extent necessary to ensure the person does not lose benefits because of the replacement.

2. **Do I need to be enrolled in Medicare Parts A and B to receive benefits?**
   The Hartford's coverage is designed to supplement the benefits of Medicare Part A & B. Although Medicare Part A coverage is automatic, an individual can elect to opt out. Part B is optional. If the individual is not enrolled in both plans of Medicare, The Hartford will pay benefits assuming the person has Medicare Part A and Part B. Thus, The Hartford's benefits will pay its portion accordingly. As a result, the individual will have significantly more out-of-pocket expenses. Generally, the claims will take a little longer to process due to the fact that it's more difficult to send payment electronically and manual calculations need to be done in order to estimate what Medicare would have paid.

3. **What if my spouse is under age 65 and not eligible for Medicare?**
   If you enroll in the Senior Medical Insurance Plan you can cover your spouse once they turn 65.

4. **What is the network area for this medical coverage?**
   There is no network for The Hartford's Senior Medical Insurance Plan. You can go to any provider that accepts Medicare and you can keep your current doctor.

5. **Do these plans include coverage for prescription drugs?**
   No. This plan works as a supplement to Medicare Parts A & B. A standalone Part D prescription drug plan would need to be purchased separately if you would like prescription drug coverage. If you currently have a Medicare supplement or Medigap policy, you may keep the Part D prescription plan you currently have. However, if you are leaving a Medicare Advantage plan that includes coverage for prescription drugs, you will need to enroll in a standalone Part D prescription drug plan if you wish to have coverage for your prescription medications.

6. **How do I cancel my current coverage if the Medicare open enrollment window has closed?**
If you currently have a Medicare supplement or Medigap policy, you can cancel your plan at any time to enroll in either of these plans. If you currently have a Medicare Advantage plan, you may switch back to Original Medicare and choose a Part D prescription plan during the Medicare Advantage open enrollment period, which runs from January 1 to March 31. This period was formerly called the Medicare Advantage Disenrollment period.

7. **Who is Benistar?**
Benistar is the Administrator handling Customer Service and Billing for The Hartford's Senior Medical Insurance Plan. You can Contact ***BENISTAR Retiree Customer Service Department at 1-800-236-4782 between the hours of 8:30 A.M. and 5:30 P.M EST***

8. **Who is WebTPA**
WebTPA is the Claims Administrator for the Hartford. They will process your claims. If you have any questions you can contact the ***Customer Service Department at 844-380-4557 Monday to Friday 7:00 A.M. central to 5:00 P.M., central.***

9. **Will I have to file claims?**
With your new medical, there is usually no need to file claims. Simply present your ID card to your health care provider when you receive services. Doctors and other health care providers file your Medicare claims with Medicare, and Medicare files your claim directly with WebTPA.

10. **How am I covered when outside of the United States?**
You have a Foreign Emergency benefit for sickness or injury during your first 60 days of travel it has a $250 deductible and 20% co-insurance until $50,000 life time max.

11. **What if my doctor says she doesn't take Hartford?**
Explain to your doctor that The Hartford is a supplemental plan which pays secondary to Medicare. The doctor just needs to submit your claim to Medicare and we will pay after Medicare pays.

Group Benefits from The Hartford

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Group Retiree Health Insurance – GRIP (The Hartford's Group Retiree Insurance Plan®) Enrollment Form
For Initial Enrollment and Subsequent Changes

Policyholder: Philadelphia Fire Fighters' Union Local 22 **Policy Number(s):** AGP-xxxxxx

Please print clearly in ink or type

Retiree's Name: _____
First Middle Last

Street: _____

City, State, Zip: _____ Medicare/HIC # _____

Phone Number: _____ Email Address: _____

Gender ☐ Male ☐ Female Date of Birth _____ Social Security # _____

Date of Retirement _____ Have you enrolled in Medicare Part B? ☐ Yes ☐ No

If no, when do you intend to enroll? _____

Spouse's Name (Only if enrolling): _____
First Middle Last

Gender ☐ Male ☐ Female Date of Birth _____ Social Security # _____

Medicare/HIC # _____ Date of Retirement _____

Has your spouse enrolled in Medicare Part B? ☐ Yes ☐ No

If no, when does he/she intend to enroll? _____

To the best of your knowledge:

1. Do you or your spouse, if enrolling, have any other health insurance including an employer health plan?
   Retiree ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

If so, please provide the information requested below:

Covered Person	Company Name	Policy Number	Kind of Policy	Effective Date	Expiration Date

2. If the answer to question 1 is yes, do you or your spouse, if enrolling intend to replace these medical or health policies with this policy or certificate? **Retiree** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

   If yes, for what reason are you (or your spouse, if enrolling) replacing the coverage?

   ☐ Additional Benefits
   ☐ Fewer benefits and lower premiums
   ☐ Integration with Medicare
   ☐ No change in benefits, but lower premiums
   ☐ Other (please specify) _____

3. Are you covered by Medicaid?
   Retiree ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

Check Desired Coverage:

	Premium Plus Plan	Premier 10 Plan
Retiree	☐	☐
Spouse	☐	☐

Complete this form answering all questions. Please be sure to date and sign the form and return to:

Michael Grugan
Karr Barth Assocs, Inc.
1 Belmont Ave. Ste. 1000
Bala Cynwyd, PA 19004

Confirmation

I acknowledge that I have been given the opportunity to enroll in the insurance offered by the Policyholder. I understand and agree that if I decline insurance now, I may not be able to enroll in the future.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the Policyholder can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

Fraud Notice(s)

For Residents of Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Residents of Louisiana:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Maryland:
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of New York:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For Residents of Virginia:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Date: _____ Retiree Signature: _____

Date: _____ Spouse Signature: _____
(if enrolling)

Public Safety Health Insurance Premium Authorization Form

		Payroll / Pension No. (include plan):
Pensioner Name:	Social Security Number:	Birth Date:
Address:	City, State, Zip:	Telephone Number:
		To Be Covered: Yes ☐ No ☐
		Deceased: Yes ☐ No ☐

Spouse / Domestic Partner (if enrolling)

Name:	Social Security Number:	Birth Date:
Address:	City, State, Zip:	Telephone Number:

Local 22 Retiree Health Plan Selections

PENSIONER

Premium Plus

65-69		70-74		75-79		80+	
$196.46	☐	$230.06	☐	$263.10	☐	$273.87	☐

Premier 10

65-69		70-74		75-79		80+	
$152.64	☐	$183.45	☐	$214.94	☐	$225.71	☐

SPOUSE / DOMESTIC PARTNER

Premium Plus

65-69		70-74		75-79		80+	
$196.46	☐	$230.06	☐	$263.10	☐	$273.87	☐

Premier 10

65-69		70-74		75-79		80+	
$152.64	☐	$183.45	☐	$214.94	☐	$225.71	☐

I hereby authorize the City of Philadelphia Municipal Retirement System to deduct the monthly premium amount set forth above from my monthly pension annuity. This will result in a decrease of my monthly pension annuity.

Signature _____ Date _____

Public Safety Health Insurance Premium Authorization Form

		Payroll / Pension No. (include plan):
Pensioner Name:	**Social Security Number:**	**Birth Date:**
Address:	**City, State, Zip:**	**Telephone Number:**

I hereby authorize the City of Philadelphia Municipal Retirement System to deduct the monthly premium amount set forth above from my pension annuity. This will result in a decrease of my monthly pension annuity.

I understand it is my responsibility, as the participant, to inform the City of Philadelphia Municipal Retirement System of any change related to my health insurance premium deduction including, but not limited to, coverage, insurance company, or premium changes. I freely accept this obligation to notify the City of Philadelphia Board of Pensions and Retirement.

I understand that the City of Philadelphia Municipal Retirement System is not responsible for lapsed premium or lapsed insurance policy coverage or any other coverage or benefit issues that may arise between my insurance carrier and myself.

I take full responsibility for the accuracy and truth of all the information I have provided and certify that I am entitled to these benefits.

I understand that by electing to participate in the federal tax exclusion, I will be decreasing my federal taxable income. This tax exclusion may not apply to state taxation.

I understand that I may not request additional tax-preferred treatment of the applicable exclusion amount (up to $3,000.00 annually), from any other qualified retirement plan (i.e. Government defined plans, 457 plans or 403(b) plans).

I understand that the City of Philadelphia Municipal Retirement System is complying with federal law by withholding insurance premiums from my pension benefits. In doing so, the City of Philadelphia Municipal Retirement System is only performing an administrative function and is only responsible for payment of premiums, as required by law.

Signature _____ Date _____

IMPORTANT LEGAL NOTICE

THE IRS HAS NOT PROVIDED GUIDANCE TO DATE ON THE APPLICATION OF THIS PROGRAM. AS A CONDITION OF PARTICIPATION IN THIS PROGRAM, THE MEMBER ACCEPTS ALL RESPONSIBILITY FOR TRUTH OF THE INFORMATION PROVIDED TO THE CITY OF PHILADELPHIA MUNICIPAL RETIREMENT SYSTEM. IN ADDITION, IN CONSIDERATION OF PARTICIPATION, THE MEMBER AGREES THAT THE CITY OF PHILADELPHIA MUNICIPAL RETIREMENT SYSTEM, ITS STAFF OR ADVISORS, AND THE CITY OF PHILADELPHIA HAVE NO LIABILITY FOR AN ADDITIONAL TAX LIABILITY, INCLUDING INTEREST AND PENALTIES THAT MAY ARISE FROM PARTICIPATION.

AS THIS WAIVER INVOLVES YOUR LEGAL RIGHTS, YOU ARE ADVISED TO SEEK COMPETENT LEGAL ADVICE PRIOR TO PARTICIPATION IN THE PROGRAM.

I UNDERSTAND AND AGREE THAT I HAVE HAD A FULL OPPORTUNITY TO HAVE MY QUESTIONS ANSWERED AND TO SEEK OUTSIDE ADVICE.

Signature _____ Date _____

WAIVER OF CLAIMS

BY SIGNING THIS FORM, I AGREE THAT I WILL NOT MAKE ANY LEGAL CLAIM OF ANY KIND AGAINST THE CITY OF PHILADELPHIA MUNICIPAL RETIREMENT SYSTEM, ITS STAFF AND ADVISORS, AND THE CITY OF PHILADELPHIA SHOULD MY PARTICIPATION IN THIS PROGRAM RESULT IN UNEXPECTED TAX LIABILITY TO ME, INCLUDING INTEREST AND PENALTIES. I UNDERSTAND MY ABILITY TO PARTICIPATE IN THIS PROGRAM IS A VALUABLE BENEFIT FOR WHICH I AM WILLING TO SIGN THIS WAIVER OF ALL CLAIMS. I FURTHER RELEASE THE CITY OF PHILADELPHIA MUNICIPAL RETIREMENT SYSTEM, ITS STAFF AND ADVISORS, AND THE CITY OF PHILADELPHIA FROM ANY LIABILITY ARISING FROM THE ADMINISTRATION OF PAYMENTS TO ANY INSURER.

Signature _____ Date _____