City of Delray Beach Police, Firefighters & Paramedics Retiree Benefit Fund
Submit via Secure Document Upload or USPS mail: Anchor Benefit Consulting, Inc. | PO Box 945260 | Maitland, FL 32794 |

2025 AFFIDAVIT OF CONTINUED ELIGIBILITY

Renewing retirees need to submit only this form. New retirees need to submit this form as well as an application for benefits.

RETIREE INFORMATION

_____ ___ _____ _____
Last Name MI First Name E-mail Address ☐**Check here if new e-mail address**

_____ _____ _____ _____
Mailing Address ☐**Check here if new address** City State Zip Code

_(_____)_____
Area Code and Phone Number ☐**Check here if new phone number**

AFFIDAVIT OF CONTINUED ELIGIBILITY: 1/1/2025 – 12/31/2025

This affidavit is executed this _____ day of _____ 20_____ by _____
Retiree Name

Confirming that I have health insurance coverage with the following company:

☐ **Benefit card in lieu of check. (*Only check box above if you want the benefit card with your entire benefit amount loaded.)***

_____ _(_____)_____
Name of Health Insurance Company Area Code and Phone Number of Insurance Company

_____ _____ _____ _____
Mailing Address City State Zip Code

_____ _____ _$_____
Insurance Policy Number Insurance Group Number Expected Annual Premium

ACKNOWLEDGEMENT

IMPORTANT: In order to be eligible to receive a benefit from the Fund, you must attach to this affidavit a copy of your MOST RECENT monthly premium statement, or proof of your current health insurance premiums. If you have an individual policy, we should be able to determine via the premium statement, the type of coverage, covered person(s), coverage period and premium amount. This benefit must be used for the purchase of health insurance or other qualified medical expenses. Note, IRS regulations provide that insurance premiums paid by an employer, or premiums that are or could be deducted pre-tax through your (or your spouse's) employer's Section 125 plan, are not eligible for reimbursement. I hereby certify that in order to receive a benefit from the Fund (1) the information provided on this affidavit is true and correct, (2) the health insurance premium amount submitted on this affidavit is an accurate statement of my unreimbursed health insurance premium expenses for the upcoming year (3) the submitted premium amount is not reimbursable from any other source and (4) the submitted insurance premiums are not paid by an employer and are not a pre-tax deduction through a section 125 cafeteria plan. I have attached a copy of my current health insurance card and had this form notarized. I understand that the benefit I receive must be used for the purchase of health insurance or other expenses allowable and included under Section 501(c)(9) and Section 213(d) (medical care) of the Internal Revenue Code.

_____
Signature of Retiree

NOTARY

State of _____, County of _____.

Before me, _____, personally appeared, known to me, or proved to me through description of an
Retiree Name
identification card or other document, to be the person whose name is shown on this form and acknowledged to me that he/she executed the same for the purposes and consideration therein expressed. Type of identification produced _____.

Given under my hand and seal of office this _____ day of 20_____.

_____ _____
Notary Public's Signature **Notary's Seal Stamp**