MONTANA TEACHERS' RETIREMENT SYSTEM

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PO BOX 200139
HELENA MT 59620-0139
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406-444-3134
1-866-600-4045

TRS Office Use Only

AUTHORIZATION FOR DEDUCTION OF HEALTH INSURANCE

PLEASE TYPE OR PRINT LEGIBLY IN DARK INK.

BENEFIT RECIPIENT INFORMATION

First________________________ Middle____________ Last_______________________________ Suffix _______
Printed Name

____
Mailing Address–Including City, State & Zip+4 Code (If unknown, use 5-digit Zip Code)

____________________________ ____________________________ X X X – X X – __ __ __ __
Area Code and Telephone Number Benefit Recipient's Date of Birth Social Security Number

I hereby authorize deduction of the monthly premium for the insurance coverage I have selected through the employing agency from my monthly Montana Teachers' Retirement System (TRS) retirement allowance. Such deduction is to remain in effect until the employing agency cancels or changes my insurance coverage amount. I also authorize future increases or decreases in the cost of the plan I selected to be automatically deducted without further authorization from me.

____ ______________________________
Benefit Recipient's Signature **Date**

EMPLOYER INFORMATION

NOTICE TO EMPLOYER**:** The benefit recipient and you are *required* to complete and submit this original form to the TRS. A staff member will then update the TRS payroll system allowing you, the employer, to commence withholding an insurance premium on behalf of the benefit recipient.

As the employer, you are responsible for processing all premium amount changes using the TRS On-Line Payroll Insurance Reporting system. You must provide a written notification of all changes to the benefit recipient *prior* to the effective date.

Upon notification of the benefit recipient's death, you **must** directly reimburse the TRS the gross monthly premium amount withheld**.**

____ ______________________________
Insurance Coordinator's Name Area Code and Telephone Number

____
Insurance Carrier's Name

____ $______________________________
TRS Six-Digit Employer Number Monthly Premium Amount

TRS monthly retirement allowances are paid on the last business day of each month. The first deduction from the monthly retirement allowance is to begin in the month of ________________________, to cover the insurance premium for the month of ___________________________.

____
Certifying Representative's Printed Name

____ ______________________________
Certifying Representative's Signature **Date**

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT OF 1992,
ALTERNATIVE ACCESSIBLE FORMATS OF THIS DOCUMENT WILL BE PROVIDED UPON REQUEST.