



MONTANA TEACHERS' RETIREMENT SYSTEM

1500 E 6TH AVE
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(406) 444-3134

TRS Office Use Only

AUTHORIZATION FOR DEDUCTION OF HEALTH INSURANCE

(PLEASE TYPE OR PRINT LEGIBLY IN DARK INK)

Monthly insurance premiums must be paid in advance. At commencement of monthly benefits, withholding can only be started on the benefit recipient's second monthly retirement allowance.

BENEFIT RECIPIENT'S INFORMATION:

Form fields for Recipient's Name, Date of Birth, Social Security Number, Home Mailing Address, City, State & Zip Code, and Area Code & Telephone Number.

I hereby authorize deduction of the monthly rate in effect for the coverage I have selected through the employing agency from my monthly retirement allowance.

Signature of Benefit Recipient and Date fields.

NOTICE TO EMPLOYER: All authorization forms, changes or cancellations must be channeled through you. You must provide written notification of changes of the premium amount to both the TRS and the benefit recipient prior to the 15th day of the effective month.

TO BE COMPLETED BY THE EMPLOYER:

Form fields for Name of Insurance Coordinator, Name of Insurance Carrier, TRS Employer Number, and Monthly Premium Amount.

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 .

Signature of Insurance Coordinator and Date fields.

TRS USE ONLY: (Empty box)

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