



Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 www.ARBenefits.org

Retirement Deduction Authorization

(Insurance Rep use only):

Date Sent: _____

District/Agency Name: _____ District/Agency #: _____

I, _____, hereby authorize you to deduct from my retirement check such amounts as necessary to pay the premiums for my health insurance plan. I further authorize you to pay such amounts to the insurance company providing such personal insurance or to its authorized representative. **This authorization remains in effect until you receive notice from me in writing that it has been changed or revoked.**

The retirement system that I participate in is: **(Check *only* one of the following)**

- Public Employees Retirement System (APERS)
- Teacher Retirement System (ATRS)
- Judicial Retirement System
- Arkansas Highway and Transportation Retirement System
- Alternative Retirement System (Valic, etc) _____ (Indicate which system)

Please refer to rate sheet to determine amount(s) to record:

Monthly Amount	Self	Self/Spouse	Self/Children	Family
Health Premium				
Basic Life Volume*				
Supplemental Life Volume*				
Dependent Life Volume*				
Total Premium*				

*State Retirees only

If a member is eligible for Medicare and does not have Part B, the plan will pay as though the member does have Part B and the member will have financial responsibility for claims incurred.

If you or your spouse have Medicare Parts A and B, please provide the following information:

Retiree

Medicare HIC # _____
 Medicare Part A Eff. Date _____
 Medicare Part B Eff. Date _____

Spouse

Medicare HIC # _____
 Medicare Part A Eff. Date _____
 Medicare Part B Eff. Date _____

Please sign, date and return within 30 days to the address above, attn: Retirement Section

Signature _____ Date _____ SSN _____

(For Office Use Only)	
Effective Date: _____	EBD Initials: _____