



Phone: (501) 682-9656      Toll Free: (877) 815-1017      Fax: (501) 682-1168      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 |      |             |               |        |

**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 \_\_\_\_\_

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| <b>(For Office Use Only)</b><br><br>Effective Date: _____ EBD Initials: _____ |
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