GROUP LIFE INSURANCE FOR IMRF RETIREES

REMEMBER THESE POINTS:

❍ As long as you have authorized premiums to be deducted from your recurring pension check, your coverage will continue until IMRF begins the deductions.

❍ All payments will be handled through deductions once IMRF has been authorized by you to do so. Do not send any premium checks to Member Benefits, your Employer, or IMRF.

❍ A deduction may not be made from your initial pension check. The first deduction may be made from your first recurring pension check (the check which is for your normal monthly benefit). This first deduction will be made in an amount sufficient to bring the premium payments up to date. Thereafter, deductions will be the same as the monthly deductions being made during your active employment.

❍ If you have questions about continuing your NCPERS Group Life Insurance coverage, which your Employer cannot answer, please call Member Benefits, at 1-800-525-8056. **DO NOT CALL YOUR RETIREMENT SYSTEM.**

❍ By signing this form, you agree to have any back premiums taken out of your first deduction and understand that this cannot be revoked in excess of 60 days.

MEMBER RESPONSIBILITIES: If you are retiring and will be receiving a pension check, are a participant in the Group Life Plan, wish to continue coverage in the program, you must complete and sign this DEDUCTION AUTHORIZATION FORM and give it to your Employer.

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MEMBER'S Deduction Authorization for Retirees
Group Decreasing Term Life Insurance Program.

I hereby authorize the IMRF to withhold the appropriate premium deduction ($9.00/$12.00/$16.00) for each month I am entitled to a retirement benefit. This premium is to be paid to Member Benefits I understand I may revoke participation in this program only by written notification to Member Benefits. I agree to have any back premiums taken out of my first deduction and understand that this cannot be revoked in excess of 60 days.

Date:__________Signature:____

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EMPLOYER RESPONSIBILITIES: To process this request, we need the following:

Member's Name: ________________________ Employer Name:__________________________________
Social Security #:________ - _________- ___________ Employer No.: ____________________________
Retirement/Actual Date Last Worked: ____________________________
Date of Last P/R Deduction by Employer: _____________ Amt of Monthly Deduct: ___________________
To Cover the Month of:________________________________

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Signature of Employer Representative

EMPLOYER RESPONSIBILITIES:

1. Make a copy of this form for your records.
2. Forward this form to the Member/Retiree to sign and date.
3. **Retiree:** Mail this completed form to:

Member Benefits
NCPERS Group Life Plan Administration
10739 Deerwood Park Blvd Suite 200B
Jacksonville, FL 32256