TRS Office Use Only



MONTANA TEACHERS' RETIREMENT SYSTEM

1500 E 6TH AVE PO BOX 200139 HELENA MT 59620-0139 (406) 444-3134

AUTHORIZATION FOR DEDUCTION OF HEALTH INSURANCE

(PLEASE TYPE OR PRINT LEGIBLY IN DARK INK)

Monthly insurance premiums <u>must</u> be paid in advance. At commencement of monthly benefits, withholding can only be started on the benefit recipient's <u>second</u> monthly retirement allowance. Accordingly, the benefit recipient must pay any premium(s) due, which arises between their date of retirement and their second monthly benefit, directly to the employing agency. All future payments will be made directly through deductions from the Teachers' Retirement System (TRS) monthly retirement allowance.

BENEFIT RECIPIENT'S INFORMATION:		
(Recipient's Name) (De	ate of Birth)	(Social Security Number)
(Home Mailing Address)		(City, State & Zip Code)
(Area Code & Telephone Number)		
I hereby authorize deduction of the monthly rate in effect for the retirement allowance. Such deduction is to remain in effect unti also authorize future increases or decreases in the cost of the p	I the employing agen	cy cancels or changes my insurance coverage amount. I
(Signature of Benefit Recipient)	_	 (Date)
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. Upon		
notification of the benefit recipient's death, you must directly rei	mburse the TRS the	gross monthly premium amount withheld.
TO BE COMPLETED BY THE EMPLOYER:		
		(
Name of Insurance Coordinator		() (Area Code & Telephone Number)
Name of Insurance Carrier		
	Monthly Premium Amount	
TRS Employer Number	Monthly Premium Amount	
Monthly retirement allowances are paid on the last business day	y of each month. The	e first deduction from the monthly retirement allowance is to
begin in the month of, to cover the insurance premium for the month of		
		<u>-</u>
(Signature of Insurance Coordinator)		(Date)
		TRS USE ONLY:

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

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