

Instructions—Insurance Premium Deduction Authorization

IF THE EMPLOYER PAYS YOUR PREMIUMS

It is not necessary to complete this form if your health insurance premiums are fully paid by your employer.

Under the provisions of the Public Employees' Medical and Hospital Care Act, if CalPERS provides your health insurance, your health insurance benefits will automatically continue provided the effective date of your retirement is within 120 days of the separation date from your employer. However, if you have any questions regarding your eligibility or if 120 days or more elapse between the date of your separation and the effective date of your retirement, please refer to the "Enrollment and Eligibility Information" portion of the *Basic Health Plans* pamphlet available from either your employer's personnel office or the Public Employees' Retirement System at 888-CALPERS.

IF YOU PAY YOUR PREMIUMS

Please continue to make premium payments to your insurance carrier until the deductions for premiums appear on your check stub or direct deposit notice. In the event a double payment is made or a double deduction is withheld, the insurance carrier, not CalSTRS, will process any reimbursement due.

Forward this form to your school district if you are continuing under a district-sponsored policy. Approval by your school district is only necessary when the insurance coverage is under a group plan. If you are arranging coverage on your own, forward this form directly to your insurance carrier or healthcare administrator.

CalSTRS cannot deduct insurance premiums before the authorization form is forwarded to us by the insurance carrier. All insurance carriers must have a third party deduction service arranged with CalSTRS. If the district administers the insurance coverage or program, then district personnel should contact CalSTRS for assistance.

SECTION A

Please provide all requested information in Section A and sign, date and send the form to your insurance carrier or employer.

SECTION B

Please provide all requested information in Section B and sign, date and forward this form to CalSTRS or the insurance carrier.

Please note the CO/DIST. CODE section requests your county and district codes. Example: Kern County, Edison, would be 15-012.

SECTION C

Please provide all requested information in Section C and forward this form to CalSTRS.

TO MAKE CHANGES

Once CalSTRS begins taking deductions, notification of a change in status, premium amount change or a request to cancel your premium deductions must be received in writing from the carrier or healthcare administrator. Please provide all requested information in Section A, sign, date and send the form to your insurance carrier or administrator.

If you find it necessary to write CalSTRS regarding the insurance premium deduction, please include your Social Security number, full name, address and telephone number including area code. This will assist CalSTRS in locating your file without disrupting the processing of your deduction authorization.

Insurance Premium Deduction Authorization

MS 0556 (Rev. 8/07)

CALSTRS

California State Teachers' Retirement System
P.O. Box 15275, M.S. 65
Sacramento, CA 95851-0275
(800) 228-5453; TTY (916) 229-3870
www.CalSTRS.com

This optional form allows CalSTRS to deduct insurance premiums from a CalSTRS benefit recipient's monthly payment. Such voluntary deductions may include health insurance premiums, long-term care premiums, dental insurance premiums and any other district-sponsored insurance premiums that are currently being paid by you. These deductions are not required, but are offered as a convenience. If your health insurance premiums are partially or fully paid by your district, it is not necessary to complete this form. **Please note: CalSTRS does not provide health or dental insurance coverage.**

After completing Section A, send this form to your district if you are continuing on a district insurance policy, or send it directly to your insurance carrier if you are arranging coverage on your own.

Section A Member Information (To be completed by member)

NAME (LAST, FIRST, INITIAL) SOCIAL SECURITY NUMBER/CLIENT ID#

ADDRESS (STREET) (APT #) TYPE OF BENEFIT PAYMENT
(retirement, disability, survivor)

CITY STATE ZIP CODE TELEPHONE NUMBER(S)

I hereby authorize the California State Teachers' Retirement System to deduct premiums or other charges for health insurance in such amounts as will be certified by the insurance carrier.

I understand that CalSTRS will forward such authorized deductions to the carrier.

I hereby release CalSTRS from liability to me or my estate for any claim arising from the nonpayment of premiums, or for premiums paid to the carrier subsequent to my death.

I will notify the insurance carrier of any change in my status.



SIGNATURE OF MEMBER

DATE (MM/DD/YYYY)

Section B Employer Information (To be completed by employer, if applicable)

School Official: Please complete this section and forward this form to the insured's insurance carrier.

Note: If the employer is the actual carrier, contact CalSTRS for assistance.

NAME (LAST, FIRST, INITIAL) () DISTRICT TELEPHONE NUMBER

SCHOOL DISTRICT (COUNTY) COUNTY/DISTRICT CODE

PRINT SCHOOL OFFICIAL'S NAME POSITION TITLE

I hereby verify that the person designated above is eligible to continue group health insurance coverage through the policy maintained by the employer.



SIGNATURE OF SCHOOL OFFICIAL

DATE (MM/DD/YYYY)



MS0556

Section C Insurance Information (To Be Completed by Insurance Carrier)

NAME OF INSURANCE PLAN

DEDUCTION CODE

NAME OF INSURED (LAST, FIRST, INITIAL)

MONTHLY PREMIUM AMOUNT

PRINT COMPANY OFFICIAL'S NAME

POSITION TITLE

Signature



SIGNATURE OF COMPANY OFFICIAL

DATE (MM/DD/YYYY)