

INS DOC

FLORIDA RETIREMENT SYSTEM PENSION PLAN Insurance Payroll Deduction Authorization Form

FBMC Benefits Management

Approved Deduction Name

FBMC-Direct Bill

(855) 565-4748

Retiree Contact Person

Retiree Contact Person's Telephone No.

The payee must authorize new insurance deductions OR the restart of a previously closed deduction. The payee is the person receiving the FRS pension payment.

PAYEE SSN: _____

DEDUCTION CODE: **408 (Health)** _____

PAYEE NAME: _____

DEDUCTION CODE: **409 (Life)** _____

I hereby authorize the Division of Retirement to deduct my insurance premium from my monthly Florida Retirement System (FRS) benefit check and make any subsequent premium changes as directed by my insurance provider. Further, I authorize FBMC to instruct the Division to deduct up to an additional \$100 each month to pay for outstanding insurance premiums, as needed. I understand that my insurance provider is responsible for notifying me of premium changes as they occur and for any refunds (if applicable.) If I am changing insurance companies I will notify the existing company of the cancellation or changes.

Payee's signature: _____

Signature required if no premium deduction (for above deduction code) from previous month's pension payment.

Address: _____

Date: _____

Telephone No: _____

Date of Birth: _____

Date Member Retired: _____

Insurance office use only. The Division of Retirement will not use this information.

408 \$ _____

409 \$ _____

FRS deductions added/updated _____ Date: _____

#135 Jackson Health System