



RICHMOND RETIREMENT SYSTEM

Health/Dental Insurance Deduction Authorization Form

PART A. MEMBER INFORMATION

| | | |
|---|---------------------|---------------------|
| 1. Name: | 2. SSN: | 3. Birth Date: |
| 4. Address: | | 5. Phone Number: |
| 6. Eligible for City Post-Retirement Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Employment Date: | 8. Retirement Date: |

PART B. HEALTH INSURANCE COVERAGE

| | | |
|--|--|---|
| 9. Type of Plan (Choose One) | | |
| <input type="checkbox"/> Southern Health HMO | <input type="checkbox"/> Southern Health POS | <input type="checkbox"/> Southern Health PPO |
| <input type="checkbox"/> Decline Health Insurance (Waiver) | | |
| 10. Type of Coverage (Choose One) | | |
| <input type="checkbox"/> Retiree Only | <input type="checkbox"/> Retiree + One | <input type="checkbox"/> Family <input type="checkbox"/> Dependent Only (Non Medicare Eligible) |

PART C. DENTAL INSURANCE COVERAGE

| | | |
|---|---|--|
| 11. Type of Plan (Choose One) | | |
| <input type="checkbox"/> DeltaCare | <input type="checkbox"/> Delta Dental PPO | <input type="checkbox"/> Decline Dental (Waiver) |
| 12. Type of Coverage (Choose One) | | |
| <input type="checkbox"/> Retiree Only | <input type="checkbox"/> Retiree + One | <input type="checkbox"/> Family |
| 13. Dental Office Selection (Only for Dominion Dental) | | |

PART D. DEPENDENT INFORMATION. Complete Part D only if you chose Retiree + One or Family Coverage.

| 14. Name: | 15. SSN | 16. Sex | 17. Birth Date | 18. Dental Office Selection or PCP |
|-----------|---------|---------|----------------|------------------------------------|
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PART E. MEMBER CERTIFICATION

I hereby certify that: 1) all of the foregoing facts are correct, 2) I have participated in the City's Health insurance program continuously for the last five (5) years, 3) I understand that I have thirty (30) days, before termination of benefits, to enroll in health and/or dental insurance after my retirement date. The Richmond Retirement System is hereby authorized to deduct such amount as may be necessary for the payment of my premiums for the above elected health and/or dental coverage from my pension benefit. This authorization will remain in effect until revoked by me, loss of eligibility to participant in the City's benefits program or until my death.

Member's Signature _____
Date _____

RRS Use Only

| | | | |
|--------------------------------|--------------------------------|------------------------|-------------------|
| Processed with Vendor(s) _____ | Set Up on Payroll System _____ | Journal Reviewed _____ | Sent to HR: _____ |
| Health Transfer Date: _____ | Health Deduction Amount: _____ | | |
| Dental Transfer Date: _____ | Dental Deduction Amount: _____ | | |