Rev. 06/11

HEALTH/DENTAL INSURANCE DEDUCTION AUTHORIZATION FORM

please type or print in ink

PART A. MEMBER INFORMATION			
1. Name:			2. SSN:
3. Address:			
4. Phone Number:			5. Birth Date:
6. Eligible for City Post-Retirement Benefits	☐ Yes	☐ No	7. Employment Date:
8. Retirement Date:			

PART B. HEALTH INSURANCE COVERAGE

9. Type of CIGNA Health Plan (Choose One)

☐ A - Premier Plan - 20/40 ☐ B - Classic Plan - 25/50 ☐ Decline Health (Waiver)

10. Type of Coverage (Choose One)

☐ Retiree Only ☐ Retiree + One ☐ Family ☐ Dependent Only (Non-Medicare Eligible)

PART C. DENTAL INSURANCE COVERAGE

11. Type of Plan (Choose One) ☐ DeltaCare ☐ Delta Dental PPO ☐ Decline Dental (Waiver)

12. Type of Coverage (Choose One) ☐ Retiree Only ☐ Retiree + One ☐ Family

13. Dental Office Selection
(Only for DeltaCare Program)

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

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 participate in the City's benefits program or until my death.

Member's Signature Date

RRS Use Only			
Processed with Healthcare Vendor(s)	☐	Health Deduction Amount:	Entered by:
Processed with Dental Vendors	☐	Dental Deduction Amount:	Reviewed by:
TEMS Deductions Turned Off	☐	Set Up on RRS Payroll System	☐

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RICHMOND RETIREMENT SYSTEM

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