Montana Teachers' Retirement System
P.O. Box 200139, Helena, MT 59620-0139
406-444-3134 ▪ 866-600-4045 ▪ trs.mt.gov

TRS Office Use Only

FORM 117: AUTHORIZATION FOR DEDUCTION OF HEALTH INSURANCE PREMIUMS

Alternative accessible formats of this document will be provided upon request.

RETIRING MEMBER: Complete this form only if you will continue coverage on your employer's group health insurance plan.

PLEASE TYPE OR PRINT LEGIBLY IN DARK INK

SECTION 1: BENEFIT RECIPIENT INFORMATION

Full Name: First _____ Middle _____ Last _____ Suffix *(Jr., Sr., etc.)* _____

XXX-XX-_____
Last 4 Digits of SSN

_____/_____/_____
Birth Date (mm/dd/yyyy)

(_____) _____
Telephone Number

Mailing Address: Street or P.O. Box _____ City _____ State _____ ZIP Code *(use Zip+4 if known)*

AUTHORIZATION: I hereby authorize deduction of the monthly premium for the insurance coverage I have selected through the employing agency from my monthly Montana Teachers' Retirement System (TRS) retirement allowance. Such deduction is to remain in effect until the employing agency cancels or changes my insurance coverage amount. I also authorize future increases or decreases in the cost of the plan I selected to be automatically deducted without further authorization from me.

_____ _____
Benefit Recipient's Signature Date

SECTION 2: EMPLOYER INFORMATION

NOTICE TO EMPLOYER: The benefit recipient and you are required to complete and submit this original form to TRS. A staff member will then update the TRS payroll system allowing you, the employer, to commence withholding an insurance premium on behalf of the benefit recipient.

As the employer, you are responsible for processing all premium amount changes using the TRS Employer Insurance Deduction System. You must provide a written notification of all changes to the benefit recipient prior to the effective date. Upon notification of the benefit recipient's death, you must directly reimburse TRS the gross monthly premium amount withheld.

_____ (_____) _____
Insurance Coordinator's Name Telephone Number

___ ___ ___ ___ ___ ___ _____ $ _____
TRS Employer Number Name of Insurance Carrier Monthly Premium Amount

TRS monthly retirement allowances are paid on the last business day of each month. The first deduction from the monthly retirement allowance is to begin in the month of _____ , to cover the insurance premium for the month of _____ .

_____ _____
Certifying Officer's Name Title

_____ _____
Certifying Officer's Signature Date