RETIREE BENEFITS CONTINUATION AUTHORIZATION

Name:	Social Security Number:	Date of Birth:
Complete Address:		
Telephone Number:	Personal Email Address:	
Last Day Worked:	Retirement Date:	Retirement type: Pension Investment

HEALTH INSURANCE: (circle plan)		
$750 Ded $1500 Ded $2500 Ded	$	ACCEPT^ DECLINE
SUN LIFE INSURANCE: Not eligible for reinstatement if not accepted at retirement. Benefit amount reduces by 35% at age 65 and again by 50% at age 70. Term insurance, no cash value. Payable to beneficiary upon death.		
• Retiree (Benefit Amount*:) *Maxmimum $20,000	$	**ACCEPT DECLINE**
• Dependent(s) ► Spouse: $10,000 ► Dependent Children**: $5,000 **unmarried, up to age 25	$ $	**ACCEPT DECLINE**
HUMANA PRODUCTS		
• Dental (circle plan)		
Dental Advantage PPO Trad Preferred PPO	$	**ACCEPT DECLINE**
• Vision	$	**ACCEPT DECLINE**
CIGNA SUPPLEMENTAL LIFE (circle benefit)		
• Benefit Amount (Reduces by 35% at age 65) $10k $20k $30k $40k	$	**ACCEPT DECLINE**
TOTAL MONTHLY PREMIUM		

YOU MUST CONTACT EACH OF THE FOLLOWING CARRIERS WITHIN 30 DAYS OF YOUR RETIREMENT TO CONTINUE THE BENEFITS LISTED BELOW:

- **Unum Group Accident/ Unum Group Critical Illness (866-679-3054)**
- **LegalShield (800-591-7311)**

<<<<< TAKE NOTE TO THE FOLLOWING REMINDERS>>>>>

- **FSA (medical expense account**) funds must be utilized by the end of the month that you are retire.
- Residual funds in an **HRA** (health reimbursement arrangement) will be available to you until they are exhausted, *if you are vested in the health plan.*
- ^Dropping ACPS health coverage upon Medicare eligibility requires 30 days advance notice, in writing (email is acceptable)

Contact Lori Bolte, Benefits Coordinator, at 352-955-7577 or email boltelk@gm.sbac.edu

TO BE COMPLETED BY RETIREE

☐ I wish to continue the following group insurance benefits: ☐Health ☐ Sun Life ☐ Dental ☐ Vision ☐ CIGNA Life

>>>If FRS Payroll deduction is authorized, I acknowledge that I may be required to pay ACPS directly for the first month of coverage due to FRS processing times. If payment is not received within 10 days from the date below, coverage will terminate in accordance with the regular timeline. (contact the Benefits Office for termination date)

Initial Here:______________

☐ I **decline** group health, dental, vision, and group term-life benefits.

Retiree's Signature: ______________________________ Date: ________________

FLORIDA RETIREMENT SYSTEM
Insurance Payroll Deduction Authorization Form

Alachua County Public Schools/ School Board of Alachua County
Name of Insurance Provider

Lori Bolte (boltelk@gm.sbac.edu) (352) 955-7577
Insurance Provider Contact Person Insurance Provider 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 NO:** 052

PAYEE NAME: ____________ **DEDUCTION CODE NO:** 065

I hereby authorize the Division of Retirement to deduct my insurance premiums from my monthly Florida Retirement System (FRS) benefit check and make any subsequent premium changes as directed by my insurance provider. 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: ____________________

Address: ____________________

Date: ____________ Telephone No: ____________

Date of Birth: ____________

Date Member Retired: ____________

Insurance Provider use only. Retirement will not use this information.

Health (code 052): ____________

Life (code 065): ____________

Form number: FIN516.002
New Date: 4/4/16