

# FLORIDA RETIREMENT SYSTEM

## Insurance Payroll Deduction Authorization Form

Humana Insurance Company

Name of Insurance Provider

Insurance Provider Staff

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: 439

Payee Name:

PAYEE MUST COMPLETE ALL SECTIONS WITHIN THIS AREA AND EMAIL FORM TO ABOVE INSURANCE PROVIDER STAFF

*By signature below, 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:

Date:

Address:

Date of Birth:

Telephone Number:

Date Retired:

School District:

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

Group #735974

Dental Div. 39 or 40

Vision Div. 39

Processing Date:

Date sent to FRS:

**Insurance provider staff** must fax or mail a completed authorization form for all new deductions (or restarted deductions) to the Division of Retirement. MAIL: Division of Retirement, Retired Payroll Section, PO Box 9000, Tallahassee, FL 32315-9000; FAX 850-410-2010