

**THE CITY OF WEST PALM BEACH
RESTATED EMPLOYEES' DEFINED BENEFIT RETIREMENT SYSTEM**

HEALTH INSURANCE DEDUCTION AUTHORIZATION FORM

NOTE: Please contact your Insurance Provider before you complete this form. You should obtain directly from them information such as correct amount of premium to be deducted from your pension payments, current coverage, etc.

I, _____, social security number _____ - _____ - _____,
(Retiree's name)

hereby authorize Pension Resource Center to deduct \$ _____ from
my pension check each month, and forward the deducted amount to the City of West Palm
Beach as payment of my health insurance premium, for the _____ coverage.
(single / family)

I understand that it is my responsibility to pay all health insurance premiums through the month where I receive my first benefit payment or initial pension check. The premium that will be deducted from my initial pension check will be for the next month following. *There will not be any retroactive premiums deductions.*

Retiree's Signature

Date

Return to:
Pension Resource Center, LLC
4360 Northlake Boulevard, Suite 206
Palm Beach Gardens, FL 33410

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