HEALTH INSURANCE CONTINUATION THROUGH EMPLOYER - PREMIUM DEDUCTION AUTHORIZATION

IMRF Form 7.10 (Rev. 08/2013)

INSTRUCTIONS

- Please submit this form **no later than** the 10th of the month prior to the month additions or changes are to take effect, e.g., submit the form no later than March 10th for the deductions to begin with the April payment.
- If you are **adding a member's deduction**, the member's signature **is** required.
- If you are **changing the amount of an existing deduction authorization**, the member's signature is **not** required.

PLEASE PRINT

SECTION 1 - MEMBER'S INFORMATION

MEMBER'S LAST NAME	FIRST NAME	MIDDLE INITIAL	(JR.SR.II,ETC)	IMRF MEMBER ID OR LAST 4 DIGITS OF SSN

HOME STREET (MAILING) ADDRESS	
CITY, STATE AND ZIP	DAYTIME TELEPHONE NUMBER (with Area Code)

SECTION 2 - MEMBER AUTHORIZATION (*required to add a member's deduction*)

I authorize and request the Illinois Municipal Retirement Fund (IMRF) to deduct insurance premiums from my IMRF benefit payment and to remit the amount deducted to the employer offering insurance. I authorize IMRF to release information to the employer offering insurance or its insurance carrier in order to ensure proper handling of premiums. I understand IMRF will adjust deductions in response to changes in the premiums. **I further understand IMRF will not deduct more than one premium from a benefit payment** (IMRF will not make-up back premiums), and that **IMRF will cease making any deduction if the premiums exceed my IMRF benefit amount.**

This authorization is not an assignment of my right to receive payment. This authorization will remain in effect with IMRF until cancelled by written notice from me or until my former employer notifies IMRF that a premium deduction is no longer required.

X _____ _____

SIGNATURE (*Check appropriate box below.*) DATE (MM/DD/YYYY)

*** Member signs if member is receiving benefit payment; spouse signs if spouse is receiving surviving spouse benefit.**

☐ MEMBER ☐ SURVIVING SPOUSE

SECTION 3 - AUTHORIZED AGENT'S CERTIFICATION (*required to add or change a member's deduction*)

THE REMITTANCE WILL BE SENT TO THE EMPLOYER IN ALL CASES

EMPLOYER NAME	EMPLOYER IMRF I.D. NUMBER
STREET (MAILING) ADDRESS	CITY, STATE AND ZIP

POLICY NUMBER	MONTHLY PREMIUM	MONTH & YEAR DEDUCTION TO BEGIN (MM/YYYY)
	$	

AUTHORIZED AGENT'S NAME (Please print.)	TITLE

DAYTIME TELEPHONE NUMBER (with Area Code)	FAX NUMBER (with Area Code)	EMAIL ADDRESS
	( )	

EMPLOYER CONTACT, IF OTHER THAN AUTHORIZED AGENT	DAYTIME TELEPHONE NUMBER (with Area Code)
	( )
SIGNATURE OF AUTHORIZED AGENT **X**	DATE (MM/DD/YYYY)

FOR IMRF USE ONLY	DATE ENTERED	DATE EFFECTIVE

IMRF
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