



**NCPERS Group Life Insurance**  
 c/o Member Benefits  
 PO Box 17639  
 Jacksonville, FL 32245-7639

## NCPERS GROUP LIFE INSURANCE - RETIREE AUTHORIZATION FORM

We have been notified by your employer of your recent retirement. While you were employed, you carried Group Life Insurance through your participation in your Retirement System. You may continue this valuable insurance coverage into retirement if you are, or will be, receiving a monthly pension check from your Retirement System.

**Remember These Points:**

- As long as you have authorized premiums to be deducted from your recurring pension check, your coverage will continue until your Retirement System begins the deductions.
- A deduction may not be made from your initial pension check. The first deduction may be made from your first recurring pension check (the check which is for your normal monthly benefit). Once the first deduction is made by your Retirement System, Member Benefits will determine the amount that is due to cover the transition period and bring your premium payments up to date. Thereafter, deductions will be made from your Retirement System for the same monthly deduction amount that was being made during your active employment.
- If you have questions about continuing your NCPERS Group Life Insurance coverage, which your Employer cannot answer, please call Member Benefits, at 1-800-525-8056. **DO NOT CALL YOUR RETIREMENT SYSTEM.**

**MEMBER RESPONSIBILITIES:** If you are retiring and will be receiving a pension check, are a participant in the NCPERS Group Life Insurance Plan and wish to continue coverage in the program, you must complete and sign this DEDUCTION AUTHORIZATION FORM and return it to Member Benefits.

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### MEMBER'S DEDUCTION AUTHORIZATION FOR RETIREES GROUP DECREASING TERM LIFE INSURANCE PROGRAM

I hereby authorize my Retirement System to withhold the appropriate premium deduction (\$16.00) for each month I am entitled to a retirement benefit. This premium is to be paid to Member Benefits I understand I may revoke participation in this program only by written notification to Member Benefits.

**Member Name:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Retiree Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**EMPLOYER SECTION:** *To process this request, please complete the following:*

**Employer Name:** \_\_\_\_\_ **Employer Unit #:** \_\_\_\_\_

**Retirement Date:** \_\_\_\_\_ **Last Deduction Date:** \_\_\_\_\_

**Monthly Deduction Amount:** \_\_\_\_\_ **Last Paid Month:** \_\_\_\_\_

**Employer Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**RETURN FORM INSTRUCTIONS:** Make a copy of this form and choose one of the following options:

- Email the completed form to: **ncpers@memberbenefits.com**
- Mail the completed form to: **PO Box 17639, Jacksonville, FL 32245-7639**