GROUP LIFE INSURANCE FOR RETIREES

REMEMBER THESE POINTS:

- As long as you have authorized premiums to be deducted from your recurring pension check, coverage will continue until PERSI begins the deductions.
- All payments will be handled through deductions once PERSI has been authorized by you to do so. Do not send any premium checks to HealthSmart Benefit Solutions, your employer, or PERSI.
- 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). This first deduction will be made in an amount sufficient to bring the premium payments up to date. Thereafter, deductions will be the same as the monthly deductions 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 HealthSmart Benefit Solutions at 1-800-525-8056. **DO NOT CALL PERSI.**

MEMBER RESPONSIBILITIES: If you are retiring and will be receiving a pension check, and are a participant in the Group Life Plan, and wish to continue coverage in the program, you must complete and sign this DEDUCTION AUTHORIZATION FORM and give it to your employer.

EMPLOYEE/MEMBER'S Deduction Authorization for Retirees
Group Term Life Insurance Program.

I hereby authorize the Public Employees Retirement System of Idaho to withhold the appropriate premium deduction ($6.00/$9.00/$12.00/$16.00) for each month I am entitled to a retirement benefit. This premium is to be paid to HealthSmart Benefit Solutions, Inc. I understand I may revoke participation in this program only by written notification to HealthSmart Benefit Solutions.

Date: _____ Signature: _____

EMPLOYER RESPONSIBILITIES: To Process this request, we need the following:

Employee/Member's Name: _____ Employer Name: Cassia County Joint Sd 151

Social Security Number: _____ Employer No: S151

Member's Mailing Address: _____

Retirement/Actual Date Last Worked: _____

Date of last P/R Deduction by Employer: _____ Amount of monthly deduction: _____

To cover the month of: _____

Signature of Employer Representative: _____

EMPLOYER RESPONSIBILITIES:

1. Make a copy of this form for your records.
2. Forward this form to the Member/Retiree to sign and date.
3. **Retiree:** Mail this completed form to:

HealthSmart
NCPERS Group Life Administration
10303 E Dry Creek Rd, Suite 200
Englewood, CO 80112