

**Public Safety Retirement System  
Elected Officials Retirement Plan  
Corrections Officer Retirement Plan**

**Health Insurance Authorization/Change Form**

Retire Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
Last First M.I.

Present Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Street Address DOB: \_\_\_\_\_  
 \_\_\_\_\_ Medicare# \_\_\_\_\_  
City State Zip Code

**Retiree information for coverage (Check all that apply)**

Male  Female

**Type of change**

**New Retiree/Survivor** Date of retirement \_\_\_\_\_ **check all that apply**

**New Add:** Member and/or Dependent (info below for dep) *Arizona State Retirement System*

**Change Coverage;**  Single  Family *Public Safety Personnel Retirement*

**Term Coverage:** *Elected Officials Retirement Plan*

Member  Dependent(s) *Correction Officers Retirement Plan*

If Death: Date of Death: \_\_\_\_\_

**Medicare change;** Medicare # \_\_\_\_\_

Member  Dependent

**Dependent Information**

Name	Relationship	D.O.B.	SS#	Medicare #	Suffix	Effective date of Medicare

This Area to be filled out by employer

**Medical plan choice**

**Dental plan choice**

Carrier: \_\_\_\_\_

Carrier: Assurant UD67

	Full Premium	City/State Subsidy	Amount Member Owes
Member			
Dependent			
Total Due			

	Full Premium	City/State Subsidy	Amount Member Owes
Member			
Dependent			
Total Due			

**I request that my health insurance premium benefit be supplied to the medical and/or dental coverage provided by my former employer and verify that the information provided above is true and accurate. I hereby authorize that premium deductions may be taken from my monthly Retirement annuity benefit check**

Retirees' Signature (and/or) Employer Rep Signature \_\_\_\_\_ Date \_\_\_\_\_

This Area to be filled out by employer

Employer Name: \_\_\_\_\_ Rep Name: \_\_\_\_\_ Employer Contact Phone: \_\_\_\_\_

Effective date:  Medical Code:  Dental Code: