* * IMPORTANT * *

FLORIDA RETIREMENT SYSTEM
Insurance Payroll Deduction Form

PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND

Name of Insurance Provider

Palm Beach County Firefighters
Employee Benefits Fund
c/o UMR
230 Lexington Green Circle, Suite 400
Lexington, KY 40503

Insurance Provider Contact Person

888-999-7741

Insurance Provider Telephone Number

The Payee must authorize new insurance deductions OR the restart of a previously closed deduction. The payee is the person receiving the FRS pension payment.

PAYEE SSN: _____ **DEDUCTION CODE NO.** 234

PAYEE NAME: _____ **DEDUCTION CODE NO.** _____

I hereby authorize the Division of Retirement to deduct my insurance premiums from my monthly Florida Retirement System (FRS) benefit check and make any subsequent premium changes as directed by my insurance provider. I understand that my insurance provider is responsible for notifying me of premium changes as they occur and for any refunds (if applicable). If I am changing insurance companies I will notify the existing company of the cancellation or changes.

Payee's Signature: _____

Address: _____

Date: _____ Telephone No.: ( )

Date of Birth: _____ Date Member Retired: _____

Insurance Provider Use Only. Retirement will not use this information.