JRF Form 12 09/08

Insurance Authorization Form

Judicial Retirement Fund of Alabama

JRF Office Use Only
Years of Service: _____ Months of Service: _____
Effective Date of Retirement: ____/____/____
Date of First Check: ____/____/____
Type of Retirement: ☐ Service ☐ Disability

Member Information *(This form **must** be signed before returning it to the JRF)*

Name _____ Date of Birth _____

Social Security No. _____ Home Phone ( ) _____

Home Address _____
Mailing Address City State Zip Code

I wish to continue my insurance under the health care plan, *in which I am currently enrolled as indicated below* , and authorize monthly premium deductions from my retirement check until otherwise notified by me, or, in case of death, my beneficiary or other proper authority.

☐ State Employees' Health Insurance Plan (Blue Cross/Blue Shield)
☐ Other Health Insurance: (Specify Insurance Plan Name) _____

I ☐ do ☐ do not wish to continue my dependent health insurance coverage for the individuals listed below:

Last Name	First Name	Middle Name	Birthdate	Sex	Relationship to Me

☐ I wish to *discontinue* Health Insurance Coverage.

Authorized Miscellaneous Insurance Deductions:

Name of Company	Policy Number	Monthly Premium

Member's Signature _____ **Date** _____

Employer Certification

I hereby certify that the above miscellaneous insurance premiums are being deducted from salary warrants issued to the above referenced individual.

Signature of Payroll Clerk _____ Date _____

If you have any questions regarding your State Employees' Health Insurance, please contact the State Employees' Insurance Board (SEIB) at 800-513-1384.