



Your SSN _____

Your Information

Name _____
First Middle/Maiden Last

Address _____
Street or P.O. Box City State ZIP Code

Daytime Telephone _____ Email Address _____

Date of Birth _____

Health Insurance Election

If you have any questions, please contact the State Employees' Insurance Board (SEIB) at 866.836.9737.

I wish to continue my insurance under the health care plan I have selected below. I authorize monthly premium deductions from my retirement check until otherwise notified by me, or, in case of death, my beneficiary or other proper authority.

Select **Only One**: State Employees' Health Insurance Plan (BCBS) BCBS Supplemental Southland Optional Plan

I wish to **discontinue** my health coverage dental coverage

I wish to **discontinue** my dependent health insurance coverage for the individuals listed below:

First Name	Middle Name	Last Name	DOB	Sex	Relationship to Me

Credit Union Deductions

I authorize the Employees' Retirement System or Judicial Retirement Fund to deduct \$ _____ from my monthly benefit payment and transmit the amount deducted to the following credit union.

Alabama State Employees' Credit Union Alabama One Credit Union Guardian Credit Union

Miscellaneous Insurance Deductions

Only available to active members who are applying for retirement

Company Name	Policy Number	Monthly Premium

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

Sign Here →
Employer

Payroll Clerk Signature _____ **Date** _____

Sign Here →
Member

Your Signature _____ **Date** _____

THIS BOX IS FOR ERS/JRF USE ONLY

Years of Service _____ Months of Service _____ Effective Date of Retirement _____

Type of Retirement Service Disability DROP Participant Yes No DROP Ended Date _____