



Your SSN _____

Your Information

No initials please

Name _____
First Middle/Maiden Last

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

Telephone Number _____ Email Address _____

Date of Birth _____

Authorization Information

I authorize the Teachers' Retirement System of Alabama to deduct the following miscellaneous insurance premiums from my retirement benefits. I understand that I must request any changes or cancellation of these premiums in writing.

| 1. | Name of Insurance Company | Policy Number | Monthly Premium | Deduction Start Date |
|---------------------------|---------------------------|---------------|-----------------|----------------------|
| | | | | |
| Insurance Company Address | | | | |
| 2. | Name of Insurance Company | Policy Number | Monthly Premium | Deduction Start Date |
| | | | | |
| Insurance Company Address | | | | |
| 3. | Name of Insurance Company | Policy Number | Monthly Premium | Deduction Start Date |
| | | | | |
| Insurance Company Address | | | | |
| 4. | Name of Insurance Company | Policy Number | Monthly Premium | Deduction Start Date |
| | | | | |
| Insurance Company Address | | | | |

Sign Here → Your Signature _____ Date _____

Employer Certification

To be completed by the employing agency

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

Member Name _____ Last Date Deducted _____

Sign Here → Employer Signature _____ Date Submitted _____

Employer

Title _____

To return form by fax: 334.517.7001

| | | |
|--|-----------------------|---------------|
| THIS BOX IS FOR TEACHERS' RETIREMENT SYSTEM USE ONLY | | |
| TRN _____ | Retirement Date _____ | 1st P/R _____ |