PHT Pension Plan

Insurance Payroll Authorization Form

FBMC Benefits Management

Retiree and Direct Bill Department • PO Box 10789 • Tallahassee, FL 32302-2789

Service Center: 855-56JHS4U (855-565-4748) Fax: 1-866-836-9943

The payee must authorize new insurance deductions selected OR the restart of a previously closed deduction. The payee is the person receiving the PHT Pension Plan.

Payee SSN: _____Payee Name: _____

I hereby authorize FBMC to have my insurance premiums deducted from my monthly pension check and to make any subsequent premium changes as directed by the insurance provider. I understand that the provider is responsible for notifying me of those changes as they occur and for any refunds. If I am changing insurance companies, I will notify the existing company of the insurance cancellation or changes.

Payee's Signature: _____

Address: _____

Date: _____ Telephone Number: _____

Date of Birth: _____ Date Member Retired: _____

EMPLOYER SECTION

Medical Deduction: _____ Dental Deduction: _____ Vision Deduction: _____

Life Insurance Deduction: _____ Legal Deduction: _____ Pet Deduction: _____

Ocenture Deduction: _____

EFFECTIVE DATE

____/____/____