Transport Workers Union Retirees' Association
Voluntary Dental/Vision Insurance
Pension Deduction Authorization and Waiver

PENSIONER'S NAME_____

PASS #_____

SOCIAL SECURITY # _____

ADDRESS: _____

STREET

_____

CITY **STATE** **ZIP CODE**

CELL/HOME PHONE NUMBER: _____

CHECK BOX FOR NEW ENROLLMENT DEDUCTIONS

		PPO – High Option
DENTAL: (check only one)	☐ $18 (DMO – MEMBER ONLY)	☐ $45 (PPO – MEMBER)
	☐ $42 (DMO – MEMBER + 1)	☐ $80 (PPO – MEMBER + 1)
	☐ $50 (DMO – MEMBER 2+)	☐ $110 (PPO – MEMBER 2+)

VISION: (optional) ☐ $16 (MEMBER ONLY) ☐ $30 (MEMBER +1) ☐ $45 (MEMBER + 2 or more)

OTHER: (optional) $ _____ **(life insurance, legal, other)**

TOTAL DEDUCTION: $_____

To New York City Transit Authority/Manhattan and Bronx Surface Transit Operating Authority:

I hereby voluntarily authorize the Authority on behalf of the **MaBSTOA Pension Fund** to deduct from any pension check which may be due me monthly, the amount shown above to the Transport Workers Union Local 100 Retirees' Association for the premium on the Supplemental Health Insurance Policy Program. I understand that if there are any problems with my deduction, I must contact TWU Retirees' Association. I understand that the Authority will make the deductions authorized only when I have sufficient pension pay to cover the deduction in full and in accordance with all other details as may be agreed upon with TWU Retirees' Association acting for itself and for me. Such deductions shall continue until termination of my pension payments or written notice by me of the revocation of this order from TWU Retirees' Association. I understand that Authority is making these deductions as an accommodation to TWU Retirees' Association and the **MaBSTOA Pension Fund**, and that the Authority shall have no liability with respect to these deductions or such payments to TWU Retirees' Association or TWU's Insurance Agent or the Supplemental Health Insurance Policy Program offered by TWU Retirees' Association or TWU's Insurance Agent or any matter related to such supplemental health benefit insurance. I understand that if I have any claim against the Authority with respect hereto, my sole remedy shall be payment by the Authority to TWU Retirees' Association of any amounts the Authority may have failed to remit, provided that, if said failure to remit is due to under-deductions, the Authority is able to effect a deduction of the full amount under-deducted, or in the event of an over-deduction payment by the Authority to me of the amount of such excess, and I hereby release the Authority from all other liability to me, my assigns, heirs or beneficiaries with respect to the deductions, the payments to TWU Retirees' Association, TWU Insurance Agent, the Supplemental Health Insurance Policy Program, any benefits paid thereunder, or any other matter related hereto.

By signing this form, you agree to remain in the plan and have deductions taken from your pension check for a minimum of 12 months.

PENSIONER'S SIGNATURE _____ **DATE** _____

TWU Retirees' Association
195 Montague Street, 3rd Fl, Brooklyn, NY 11201
212-873-6000 Ext. 2077, 2161, 2076 347- 916-0574 (Fax)
retirees@twulocal100.org