Transport Workers Union Retirees' Association

Voluntary Dental/Vision Insurance
Pension Deduction Authorization and Waiver

NYCERS

Pensioner Name _____

Pension Number _____

Social Security Number _____ _____ _____

Address _____
Street

_____
City State Zip Code

Cell/Home Phone Number _____

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.

☐ I hereby authorize **NYCERS** to deduct from my pension check on a regular monthly basis an amount sufficient to pay the premiums for my insurance policy and or any renewal of such policy, and to remit such amounts each month to the TWU Retirees' Association.

☐ I hereby authorize **NYCERS** to change the amount of the deduction in the event an adverse underwriting decision is made or to reflect any changes in coverage I may request.

DENTAL: (check only one)

☐ **$18 (HMO –MEMBER)**
☐ **$42 (HMO MEMBER + 1)**
☐ **$50 (HMO – MEMBER 2+)**
☐ **$45 (PPO –MEMBER)**
☐ **$80 (PPO –MEMBER +1)**
☐ **$110 (PPO – MEMBER 2+)**

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

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

TOTAL DEDUCTION: $_____

_____ _____ _____
Pensioner Name – Please Print **Pensioner Signature** **Date**

For TWU Office Use Only

Member Number _____ Current Paid Member _____

Single/Family _____ Forward to NYCERS _____

TWU Retirees Association
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