Warrant Deduction Authorization - CalSTRS Dues & Insurance Deductions Service

MS-0556 rev. 04/19

As a CalSTRS benefit recipient, you are able to request certain deductions for dues and insurance premiums to be automatically deducted from your monthly benefit. The completion of this form authorizes automatic deductions to be set up with CalSTRS for the payment of your association dues and/or insurance premiums from your monthly warrant.

To arrange for these deductions, you must complete the *Warrant Deduction Authorization* form and return it to your employer or third party organization (TPO). If the employer or TPO has an agreement with us to participate in our Dues & Insurance Deductions program, once authorized, they will instruct CalSTRS to initiate the deductions from your monthly retirement benefit. Once we begin deductions, notification of a status change, premium amount change, or a request to cancel your premium deductions must be received from the employer or TPO.

Please continue to make premium payments to your employer or TPO until the deductions appear on your warrant check stub or direct deposit notice. In the event of a double payment, or if you have any questions regarding the deductions, contact your employer or TPO directly.

IMPORTANT HEALTH INSURANCE INFORMATION: If your employer pays your premiums in full, it is *not* necessary to complete this form. If you have questions, refer to either your employer's personnel office or the California Public Employees' Retirement System at 888-CALPERS.

Instructions:

SECTION 1: MEMBER INFORMATION

Provide all requested information in Section 1 and sign, date and send the form to your employer or TPO.

SECTION 2: EMPLOYER INFORMATION/ THIRD PARTY ORGANIZATION/INSURANCE INFORMATION (TO BE COMPLETED BY EMPLOYER OR TPO)

Provide all requested information in Section 2 and retain a copy for your records.

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Complete this form to authorize deductions from your monthly benefit payment. Deductions may include dues, health insurance premiums, long-term care premiums, dental insurance premiums and/or any other district-sponsored insurance premiums (hereafter, "Deductions"). These Deductions are not required but are offered as a convenience.

Section 1: Member Information (To be completed by member)

NAME (LAST, FIRST, INITIAL)

CLIENT ID OR SOCIAL SECURITY NUMBER

MAILING ADDRESS

TYPE OF BENEFIT PAYMENT (retirement, disability, survivor)

( )

CITY | STATE | ZIP CODE

HOME TELEPHONE

EMAIL ADDRESS

I hereby authorize the California State Teachers' Retirement System to make those Deductions certified by my third party organization from my monthly benefit and remit such authorized Deductions to my third party organization.

In consideration for the service provided by CalSTRS, and to the fullest extent permitted by law I hereby (for myself, heirs, representatives and estate) waive, release and forever discharge CalSTRS and its board members, officers, advisors, managers, agents and employees from any and all responsibility, claims, causes of action, lawsuits, liability and/or damages which arise out of or are related to, directly or indirectly, the payment or nonpayment of insurance premiums or dues.

I take full and complete responsibility for notifying my third party organization of any change in my status or to make any changes relating to this deduction service.

MEMBER SIGNATURE

DATE (MM/DD/YYYY)

Section 2: Third Party Organization Information (To be completed by employer/third party organization)

NAME OF THIRD PARTY ORGANIZATION

PLAN CODE(S)

SCHOOL DISTRICT | COUNTY | COUNTY/DISTRICT CODE

PRINT OFFICIAL'S NAME

POSITION TITLE

I hereby certify that I am authorized to legally bind the organization listed herein and that the person designated in Section 1, above, is eligible to continue insurance coverage through the policy maintained by the employer.

OFFICIAL'S SIGNATURE

DATE (MM/DD/YYYY)

MS0556