HEALTH INSURANCE DEDUCTION AUTHORIZATION FORM

Participant Information (Please print or type):

Name	xxx-xx- **Social Security No.**
Street Address	
City and State	**Zip + 4 Code**
Email:	**Telephone Number**

I authorize the **Howard County Retirement Plan** to deduct monthly health insurance premiums of **$**_____ *(Amount)* from my Retirement check beginning_____. *(Date)*

Signature **Date**

Summary of Coverage *(Completed by Human Resources)*

Under Age 65 Options	**Over Age 65 Options**	**Dental Options**
☐ Aetna PPO	☐ Aetna Medicare Advantage 95	
☐ Aetna Select Open Access	☐ Aetna Medicare Advantage 10	☐ Delta Dental PPO Plus
☐ Kaiser Permanente	☐ Kaiser HMO Cost Plus	☐ Dominion Dental

Coverage Level	**County Contribution**		
☐ Individual	☐ 0%	Retirement Date:	_____
☐ Parent & Children	☐ 50%		
☐ Husband & Wife	☐ 75%	Years of Retiree	
☐ Family	☐ 90%	Health Insurance Policy	
	☐ 100%	Service:	_____

	Medical	**Spouse Medical**	**Dental**
Full Premium Cost:			
Minus County Contribution:			
Minus Spouse Contribution:			
Net Retiree Cost:			