



MEMBER ID: _____

Complete this form to authorize your health benefit payments to get deducted automatically from your monthly annuity payments.

PERSONAL INFORMATION

Name of Member: _____ Date of Birth: _____

Address: _____ City _____ State ____ ZIP _____

Cell Phone: (____) _____ - _____ Home Phone: (____) _____ - _____ Email: _____

HEALTH BENEFITS AUTOMATIC CREDIT REDUCTION*

Indicate if you would like to Start or Stop having the following premiums deducted from your monthly Annuity Benefit

MEDICAL Start Deductions [] or Stop Deductions []

DENTAL Start Deductions [] or Stop Deductions []

LIFE INSURANCE AND DISABILITY INCOME BENEFITS (LIDI) Start Deductions [] or Stop Deductions []

* To stop a benefit, please complete the ["Termination of Benefit/Employment"](#) form on PBUCC.com > Forms

* Withdrawals will include dependents, if applicable.

* The Automatic Credit Reduction (ACR) feature is not available if total deductions (including current tax withholding) reduce annuities to monthly net payment values less than \$50.

MEMBER CONSENT

I hereby give consent for monthly health benefit premium payments, as selected, to be automatically withdrawn from my monthly annuity disbursements. I acknowledge that health plan enrollments continue year-over-year annually until notice to change or terminate plan elections are received.

By signing this form, the Pension Boards is authorized to process automatic withdraws of the selected health benefit premiums at the next available billing cycle and until notice to discontinue is received.

Signature: _____ Date: ____/____/____

Please return this signed and completed form by email to: info@pbucc.org; by fax: 212.729.2701; or mail to: Pension Boards-UCC, 475 Riverside Drive, Suite 1020, New York, NY 10115.