Allegiant Care
HEALTH BENEFITS FOR TEAMSTERS

P.O. Box 4604 • 800.258.9732
51 Goffstown Road • 603.669.4771
Manchester, NH 03108 • f 603.666.4477

Pension Deduction Authorization

I, _____(member/pensioner's full name), hereby authorize New England Teamsters and Trucking Industry Pension Fund to deduct from my monthly pension check the cost of medical and/or prescription coverage under the Allegiant Care Retiree Program for myself and/or my spouse (if applicable) and to forward said sum to Allegiant Care. I understand this authorization will automatically renew each year unless I provide written instructions to cancel the deduction and that my deduction will be automatically adjusted for any increases to the premium.

I understand that if my authorization is submitted and processed by the 15th of the month, it shall become effective on the first day of the month following the execution date of this form. If Allegiant Care receives this form after the 15th of the month, it will not become effective until the first day of the second month following execution. I understand that I am responsible to remit my premium payments directly to Allegiant Care until the automatic deduction is in effect.

Member's Full Name		Date of Birth / /	SSN (last 4 digits)
Primary Phone ( )	E-mail Address		
Member's Signature:		**Date:**	

OR

❒ **I DO NOT** receive a New England Teamsters Pension. (check box and complete below)

Member's Full Name		Date of Birth / /	SSN (last 4 digits)
Primary Phone ( )	E-mail Address		
Member's Signature:		**Date:**	

Return your completed form to the mailing address noted above.
You may also fax it directly to 603-666-4477 or email retirees@myallegiantcare.com.
Retain a copy of this form for your records.

Office Use Only
Member: _____
Spouse: _____
Year: _____