NEW HAVEN RETIREE BENEFIT TRUST
AGREEMENT FOR PREMIUMS PAYMENT
FOR DISTRICT HEALTH PLAN

Retired Employee _____

Spouse/Domestic Partner Name _____

Mailing Address _____

_____

Telephone _____ E-mail_____

Health Plan Name _____

District Plan Medical Premium $_____

Deduct Benefit Trust Allowance $_____

Balance Due..... **$**_____

I agree to make any resulting premium payment balance which exceeds the retiree benefit trust allowance and agree to submit the payment to the District by the 1st of the month.

I also understand that if I miss 2 payments for district coverage, that I will be placing my coverage in risk of cancellation.

Signature _____ Date_____