REVOCABLE AUTHORIZATION

Please complete and return this authorization form to insure that your Health & Welfare Benefit coverage is not interrupted. **We must receive your authorization as soon as possible.**

Effective with my retirement date, the **Southern California UFCW and Drug Employers Pension Fund** will deduct $20.00 (Medicare enrollee) or $60.00 (non-Medicare enrollee) per month for myself and an additional $20.00 (Medicare enrollees) or $60.00 (non-Medicare enrollees) per month for each eligible dependent (*spouse and/or children*) covered under the Southern California Drug Benefit Fund Retiree Health Plan.

I authorize the **Southern California UFCW Drug Employers Pension Fund** to deduct Retiree Medical co-premiums for myself and/or the following eligible dependents as shown below:

Please check the appropriate box or boxes below:

- ☐ **$____.00** for myself only
- ☐ **$____.00** for myself and my spouse
- ☐ A**dditional $____.00** for each eligible child listed below:
  1. _____
  2. _____
  3. _____

The full amount deducted from my monthly Pension Payments will be paid to the Southern California Drug Benefit Fund on my behalf. **This authorization shall remain in effect until I notify the Pension Fund in writing of any changes.**

Signature _____ **Date** _____

Print Name _____ **SS#** _____

Should you have any questions, please contact the Pension Department.
Toll Free Number (877) 999-8329 extension 500