PHIP Payment Option Form

PERS HEALTH INSURANCE PROGRAM
Public Employees Retirement System

Complete and send form to:

PERS Health Insurance Program, P.O. Box 40187, Portland, OR 97240-0187
Phone: (503) 224-7377 or (800) 768-7377 | Fax: (503) 765-3452 or (888) 393-2943

Please note: This form must be received by PHIP no later than the 5th of the month in order for this change to be processed by the next billing cycle.

PERS Retiree Last Name	First	MI	PERS Retiree SSN and/or PERS ID#
Spouse Last Name	First	MI	Spouse Social Security No.

☐ Option 1: Pension Deduction

Description: The monthly health insurance premium is automatically deducted from the PERS retiree's monthly pension check. To choose this option, your pension must be sufficient to cover the entire monthly premium; partial premiums cannot be deducted.

I hereby authorize PERS Health Insurance Program (PHIP) to deduct my monthly premiums for medical and/or dental insurance from my monthly PERS pension benefit. I also understand that it may take up to 90 days for the premiums to begin deducting. ***In order for my health insurance to be kept current, I will receive a monthly invoice and be responsible for remitting payment by the first of each month until the deduction begins.**

Pension holder's signature X	Date

☐ Option 2: Electronic Funds Transfer (EFT)

Description: The monthly health insurance premium is electronically deducted from the checking or savings account at the beginning of each month.

9-digit routing no. *Account no.*

Please attach a voided check for a checking account or a deposit slip for a savings account.

Routing number	Account number

I understand that this authorization will remain in full effect until PERS Health Insurance Program and my bank have received written notification from me of its termination in such time and in such manner as to afford PERS Health Insurance and my bank a reasonable opportunity to act on it. I also understand that it may take up to 90 days for the premiums to begin deducting. ***In order for my health insurance to be kept current, I will receive a monthly invoice and be responsible for remitting payment by the first of each month until the deduction begins.**

Authorized signature X	Date

Power of Attorney (if applicable)

Form completed by (Name)*	Relationship to Enrollee
Signature X	Date

**Please attach legal documentation if you are the holder of a Power of Attorney*

Important notice

Oregon Administrative Rule **459-035-0090:** (3) If payment is by check or money order, the check or money order must be physically received by the Third Party Administrator on or before the due date. (4) Failure to make the payment by the due date shall result in termination of a person's PERS-sponsored health insurance coverage. Once health insurance coverage is terminated, you may not re-enroll unless you experience a new enrollment opportunity.