Transamerica Worksite Marketing

Neil Passman
Attn: State of Louisiana - Broker Office
377 Hwy. 21, Suite 100
Madisonville, LA 70447

Name		Phone Number		
SSN:	DOB:	Age:	Hired:	Gender:
Address	City	State	Zip	

LOUISIANA STATE EMPLOYEE RETIREES

Authorization for **Transamerica** change premium payment from the State of Louisiana payroll deduction

Retirement Date: _____/_____/_____ **Dept. Retired From**: _____

Elect one choice:

☐ 1. **I would like to be billed direct Annually-** (12 times the monthly premium and bill direct to the address above)

☐ 2. **I would like to be billed direct Semi Annually-** (6 times the monthly premium and bill direct to the address above)

☐ 3. **I would like to be billed direct Quarterly-** (4 times the monthly premium and bill direct to the address above)

☐ 4. **I would like to have my monthly premium DRAFTED from my checking account.** (Please complete and sign the enclosed Transamerica ACH/Bank Draft form and return along with a **Void** check to the address above)

☐ 5. **I would like to have my premium DEDUCTED from my monthly LASERS retirement check** (Please allow about 1 months for Transamerica to transition your policy(ies) from the State of LA group billing to **LASERS –*0D181*** group billing deduction to begin.)

* *I authorize the listed premium (s) to be deducted from my **LASERS** retirement check each month and remit the total premium amount to **Transamerica Worksite Marketing.***

Policy number(s) : _____ Premium amount: _____

_____ _____

* *Our office will work with Transamerica to request the transition of your policy(ies) from the State of Louisiana Group Billing Invoice to **LASERS group billing**. **Please ensure that the month you retire your final payroll deduction is for the total monthly premium.** In the event that any premium deduction is partial or missed it is the responsibility of the policyholder to send a payment to cover the premium due. Please make check or money order payable to **Transamerica Worksite Marketing** for any premium(s) due along with this form and mail it to the above address.*

Have any questions? 1-800-411-0182/985-845-7191. Fax#: 985-845-8849.

I utilize the services of the broker office for the State of Louisiana, Combined Benefits Administrators Inc., to process this authorization form and assist me in the transition to a new mode of payment upon receipt by Transamerica. I further acknowledge that Combined Benefits Administrators, Inc. does not perform the billing or payroll deductions, is not responsible for ensuring coverage under Transamerica and is not an underwriter, administrator or trustee of the Plan. Effective dates are contingent upon Transamerica sending a confirmation letter to the insured.

_____ _____

Retiree Signature Date