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

Retired Employee ____

Spouse/Domestic Partner Name ________________________________

Mailing Address ____

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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 ________________________

01/01/06
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