



LABORERS' AND RETIREMENT BOARD EMPLOYEES' ANNUITY AND BENEFIT FUND OF CHICAGO

ANNUITY ASSIGNMENT AUTHORIZATION FORM

PURPOSE:

The purpose of this Annuity Assignment Authorization Form ("Form") is to authorize the Laborers' and Retirement Board Employees' Annuity and Benefit Fund of Chicago ("LABF") to assign all or a portion of a monthly annuity payment for the purpose of paying health insurance premiums on behalf of annuitant payees who elect to enroll in plans offered by third-party health insurance providers listed below in Section 2 of this Form. The LABF requires this Form to comply with Section 11-223.2 of the Illinois Pension Code (40 ILCS 5/11-223.2).

INSTRUCTIONS:

• Carefully read and complete the entire Annuity Assignment Authorization Form.

• Return signed Form to:

For all Blue Cross Blue Shield of IL plans:

Mail: LABF of Chicago
321 North Clark Street, Suite 1300
Chicago, IL 60654-4739
Fax: 312-236-0574
Email: insurance@labfchicago.org

For all Aetna plans:

Mail: Doyle Rowe Ltd.
1301 West 22nd Street, Suite 101
Oak Brook, IL 60523
Fax: 630-379-0857
Email: info@doylerowe.com

• If you have any questions regarding enrollment in any of the third-party plans listed in Section 2, contact the appropriate provider or administrator.

SECTION 1 – LABF ANNUITANT PAYEE INFORMATION (Please PRINT)

FIRST NAME	MIDDLE INITIAL	LAST NAME	SUFFIX (e.g. Jr, Sr)
DATE OF BIRTH	LAST 4 DIGITS OF SSN or LABF OFFICE NUMBER	PHONE NUMBER (w/area code) ()	

SECTION 2 – LIST OF THIRD-PARTY HEALTH INSURANCE PROVIDERS & ASSOCIATED PLANS

- **City of Chicago** (plans administered by Blue Cross Blue Shield of IL and available to City of Chicago retirees who retired before August 23, 1989 and their dependents/beneficiaries)
- **Blue Cross Blue Shield of IL** (plans sponsored by the City of Chicago and available to City of Chicago retirees who retired on or after August 23, 1989 and their dependents/beneficiaries)
- **Aetna** (plans sponsored by the Labor Benefits Association and available to City of Chicago retirees and their dependents/beneficiaries)
- **Blue Cross Blue Shield of IL** (plans sponsored by the Chicago Board of Education and available to Chicago Board of Education retirees and their dependents/beneficiaries)
- **Blue Cross Blue Shield of IL** (plans sponsored by Chicago pension funds and available to pension fund retirees and their dependents/beneficiaries)

NOTE: PLEASE BE ADVISED THAT THE LABF, AS A MATTER OF LAW, CANNOT AND DOES NOT ENDORSE ANY HEALTHCARE PLANS, INCLUDING THOSE DESCRIBED IN THIS SECTION 2.

SECTION 3 – TERMS AND CONDITIONS

1. As an annuitant payee of the LABF, you may use this Form to authorize the LABF to deduct one or more health insurance premiums and remit payment(s) to one or more health insurance providers listed in Section 2 above.
2. The LABF is solely performing an administrative function in compliance with Section 11-223.2 of the Illinois Pension Code [40 ILCS 5/11-223.2].
3. The LABF will only deduct a premium based on direction the LABF receives from one or more of the health insurance providers listed in Section 2 above, with the understanding that this action may require revisions and adjustments. Any dispute regarding deduction amounts is solely between you and the health insurance provider you select. If the premium exceeds your net annuity payment, the LABF will not deduct any premium; in this case, you are responsible for direct payment to your health insurance provider.
4. You release the LABF, its staff, its officers, its Board of Trustees, and any of its advisors of any liability arising from the deduction of health insurance premiums from your annuity for the purpose of making payments on your behalf to one or more health insurance providers you select.

SECTION 4 – ANNUITANT PAYEE AUTHORIZATION

I, the Annuitant Payee named above, hereby: (1) certify that I have read and understand the Terms and Conditions stated above, (2) certify that the information I have provided on this Form is true and accurate to the best of my knowledge, (3) authorize and request the LABF to make health insurance premium payments on my behalf, through a deduction from my annuity benefit, to one or more of the health insurance providers listed in Section 2 of this Form, (4) acknowledge that this authorization will remain in full force and effect until I expressly change or revoke it in writing, and (5) that changing or revoking this authorization does not release me from any current or future financial obligation to any health insurance provider I may select from those listed in Section 2 of this Form.

SIGNATURE OF ANNUITANT PAYEE _____ DATE _____