TEACHERS' RETIREMENT BOARD
165 Capitol Avenue
Hartford CT 06106-1673
1 (800) 504 – 1102
Healthinsurance.trb@ct.gov

AUTHORIZATION AGREEMENT TO DEBIT YOUR ACCOUNT

Name: ________________________________ Social Security Number: ______________________

Date of Birth: ______________________________ Phone #: ______________________________

TRB Retiree Member # or SSN: Monthly Premium: $ Start Date:

I hereby authorize the Teachers Retirement Board to initiate debit entries to my account at the financial institution named below.

Bank Name: ________________________________ **Branch:** ________________________

City: ____________________________________ **State:** ________________________

Routing # ____

Bank Account # ____

Type of Account ☐ **Checking** ☐ **Savings**

This authorization is to remain in full force and effect until the Teachers Retirement Board has received written notification from me of its termination in such time and in such manner as to afford the Board and financial institution the opportunity to act upon it.

Name: ____________________________________
(PLEASE PRINT)

Signature: ____ Date: __________________

RETURN WITH A BLANK VOIDED CHECK AND A PHOTOCOPY OF YOUR MEDICARE CARD TO:

CT Teachers' Retirement Board
165 CAPITOL AVENUE
Hartford, CT 06106-1659
You may also Fax to (860) 622 – 2849