MUNICIPAL EMPLOYEES'
RETIREMENT SYSTEM
OF LOUISIANA

SURVIVOR INSURANCE PREMIMUM DEDUCTION AUTHORIZATION

R.S. 11: 1823(22)

SURVIVOR INFORMATION

First Name:	Middle Initial:	Last Name:	Last 4 Digits of SSN:
Mailing Address:			
City:		State:	Zip Code:
Phone Number:		Email Address:	
Name of Retiree from MERS:			Employer:

I hearby authorize the Municipal Employees' Retirement System of Louisiana to deduct from my monthly retirement check the amount shown below. The amount may be adjusted upon the employer's notification to MERS.

Survivor's Signature **Date of Signature**

EMPLOYER CERTIFICATION

Monthly Premium to be Deducted $_____ **Effective Date: _____**

Signature of Authorized Representative **Date of Signature**

FOR MERS OFFICE USE ONLY

Survivor's Effective Date:	Date of Survivor's First Payment:
Monthly Benefit:	Reviewed By:

RETAIN A COPY FOR YOUR RECORDS

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