OKLAHOMA MUNICIPAL RETIREMENT FUND

**Form RM-9.01**

Clear Form

## OKLAHOMA MUNICIPAL RETIREMENT FUND

# Municipality Authorization to Remit Insurance Premium Payment

OkMRF
1001 NW 63rd Street
Suite 260
Oklahoma City, Oklahoma 73116

This letter is our direction and your authorization to remit the monthly insurance premium payments to the _____. The payments should be paid from our OkMRF Health Care Plan which is a sub-account of the _____ Defined Benefit Plan pension fund. The payments are for health insurance coverage for the following person in the amounts designated below, and should be continued as designated until notified otherwise.

**Pensioner's Name** _____

**Amount of Monthly Premium** _____

**Number of Months to be Paid** _____

**Date of First Payment** _____

**Date of Final Payment** _____

The _____ understands that if the insurance coverage is stopped for any reason, that it is the _____ responsibility to notify OkMRF to cease all future payments.

_____ _____

**Date** **Authorized Agent's Signature**