VOLUNTARY PAYROLL DEDUCTION ENROLLMENT

Employee Authorization Form

COMPANY NAME

_____

DATE

_____

EMPLOYEE INFORMATION

EMPLOYEE FULL NAME

_____

EMPLOYEE ID / SSN (LAST 4 DIGITS)

_____

DEPARTMENT

_____

JOB TITLE

_____

DEDUCTION AUTHORIZATION & DETAILS

Please select the voluntary deductions you wish to authorize and specify the amount to be withheld from each pay period.

Select	Deduction Type / Plan Name	Pre-Tax	Post-Tax	Amount ($) or Percentage (%) Per Pay Period
☐	Health Insurance	☐	☐	
☐	Dental Insurance	☐	☐	
☐	Vision Insurance	☐	☐	
☐	Retirement / 401(k) / 403(b)	☐	☐	
☐	Health Savings Account (HSA) / FSA	☐	☐	
☐	Life / Disability Insurance	☐	☐	
☐	Other:	☐	☐	

AUTHORIZATION STATEMENT

I hereby authorize my employer to withhold the designated amount(s) listed above from my earnings each pay period. This authorization is voluntary and will remain in effect until I submit written notification to change or terminate these deductions, or until my employment ends. I understand that if my earnings are insufficient to cover the authorized deductions, no withholding will occur for that pay period and I am responsible for making direct payments if applicable.

EMPLOYEE SIGNATURE

_____

DATE

_____

HR / PAYROLL REPRESENTATIVE SIGNATURE

_____

DATE

_____