Pre-Tax Health & Retirement Deduction Authorization

EMPLOYEE INFORMATION

Employee Name: _____ **Employee ID:** _____

Department: _____ **Job Title:** _____

Pay Period Start: _____ **Pay Period End:** _____

PRE-TAX HEALTH DEDUCTIONS

DEDUCTION TYPE	EMPLOYEE CONTRIBUTION ($ / %)	EMPLOYER CONTRIBUTION (IF APPLICABLE)
Medical Insurance		
Dental Insurance		
Vision Insurance		
Health Savings Account (HSA)		
Flexible Spending Account (FSA)		

PRE-TAX RETIREMENT DEDUCTIONS

RETIREMENT PLAN TYPE	EMPLOYEE PRE-TAX CONTRIBUTION ($ / %)	EMPLOYER MATCH RATE
Traditional 401(k)		
Traditional 403(b)		
SIMPLE IRA		
Other:		

SUMMARY OF TOTALS

Gross Earnings for Period:	
Total Pre-Tax Health Deductions:	
Total Pre-Tax Retirement Deductions:	
ADJUSTED TAXABLE INCOME:	

Employee Signature Date

Payroll Administrator Signature Date

Authorization Note: I hereby authorize my employer to make the pre-tax reductions indicated above from my gross earnings. I understand that these pre-tax deductions reduce my taxable income for federal, state, and local income taxes, as well as FICA taxes (where applicable). I acknowledge that these selections cannot be altered until the next open enrollment period, unless I experience a qualifying life event.