EMPLOYEE BENEFITS PAYROLL DEDUCTION AUTHORIZATION

Enrollment & Deduction Change Form

EMPLOYER INFORMATION

COMPANY NAME

GROUP POLICY NUMBER

EMPLOYEE INFORMATION

EMPLOYEE FULL NAME

EMPLOYEE ID / NO.

SOCIAL SECURITY NUMBER (LAST 4 DIGITS)

DEPARTMENT / DIVISION

EFFECTIVE DATE OF DEDUCTIONS

BENEFIT PLAN ELECTIONS & DEDUCTION SCHEDULE

BENEFIT TYPE	COVERAGE LEVEL	EMPLOYEE COST (PER PAY PERIOD)	PRE-TAX	POST-TAX
Medical Insurance			☐	☐
Dental Insurance			☐	☐
Vision Insurance			☐	☐
Group Life Insurance			☐	☐
Short-Term Disability			☐	☐
Long-Term Disability			☐	☐
Flexible Spending Account (FSA)			☐	☐
Health Savings Account (HSA)			☐	☐
Retirement Plan (401k / Other)			☐	☐
Other:			☐	☐
TOTAL PER PAY PERIOD DEDUCTIONS:				

AUTHORIZATION & AGREEMENT

I hereby authorize my employer to deduct from my earnings each pay period the amounts indicated above representing my share of the premiums for the benefits select plan(s). I understand that this authorization will remain in effect until I submit a written change or termination request, or until my employment terminates. I acknowledge that pre-tax deductions will reduce my taxable income and cannot be changed during the plan year unless I experience a qualifying life event.

Employee Signature

Date

Human Resources / Payroll Representative Signature

Date