

EMPLOYEE PAYROLL DEDUCTION AUTHORIZATION FORM

Employee Name:		SSN:	
Effective Dat	:e:		_
Payroll Deduct	tions: (Please chec	k all that are applica	ble)
	Coverna	Voc	Nie
NA.	Coverage	Yes	No
	edical		
	ental		
Vi	sion		
I agree that my gross pay will be reduced by the amount of my deduction for the employee benefits indicated above. In the event of a deduction change during the year, my employer is authorized to deduct the new amount from my pay. In the event a new Employee Deduction Authorization Form is not executed on or before the next year-end, this form shall be deemed to continue in force for the next succeeding year.			
		main in effect for the b in order to be eligible to	
Emplovee Sid	anature:	D	ate: