EMPLOYEE PAYROLL DEDUCTION AUTHORIZATION FORM

Employee Name: _____**SSN**:_____

Effective Date: _____

Payroll Deductions: (Please check all that are applicable)

Coverage	Yes	No
Medical		
Dental		
Vision		

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.

I understand that this election will remain in effect for the benefit year and that I must experience a qualified life event in order to be eligible to change or revoke my election.

Employee Signature: _____ **Date**:_____