Commonwealth of Massachusetts

PAYROLL DEDUCTION AUTHORIZATION FORM (PDA) FOR INSURANCE OR OTHER EMPLOYEE DEDUCTIONS

Please check one of the following: New Deduction: ____   Change Deduction: ____

Please remit my payroll deduction to:

Vendor:_____

Address:_____   **Current Amount: $**_____

_____   **New Amount: $**_____

Policy/Account#:_____   **Vendor ID:**_____ (Payroll Dept Use Only)

TOTAL PAYROLL DEDUCTIONS: $_____   **LIMITED BALANCE: $**_____ **(If applicable)**

FREQUENCY:_____

Agency/Dept:_____**(Employer)**

Employee Name:_____   **Bargaining Unit:** _____

Employee ID:_____

Address:_____

City:_____   **State:**_____   **Zip Code:**_____

Home Phone: (_____**)** _____

I hereby authorize my Employer, named above, to deduct from my salary and to remit to the above named Vendor until further notice the amount at the frequency identified above.

It is understood that my Employer will forward the said payments to the Vendor during the continuance of my employment by said Employer or until this authorization is revoked by me with sixty days notice in writing to the said Employer.

I understand that my Employer is responsible for the correct remittance of said payment to the above named Vendor.

Employee Signature:_____   **Date:**_____