Payroll Deduction Authorization Form

(Note: All costs below are WEEKLY deduction amounts)

Medical Insurance

□ No Coverage

Plan A	Plan B	Plan C
□ Employee Only - $30.00	□ Employee Only - $20.00	□ Employee Only - $10.00
□ Employee & Spouse - $75.00	□ Employee & Spouse - $57.00	□ Employee & Spouse - $35.00
□ Employee & Child(ren) - $50.00	□ Employee & Child(ren) - $35.00	□ Employee & Child(ren) - $20.00
□ Family - $80.00	□ Family - $60.00	□ Family - $40.00

Health Savings Account (HSA)

□ Decline Participation

□ Weekly Deduction of $_____

Vision Insurance

□ No Coverage

□ Employee Only - $1.67
□ Employee & Spouse - $3.27
□ Employee & Child(ren) - $2.82
□ Family - $4.71

First week's deduction $_____

Note: The weekly deduction for Vision is higher the very first week due to billing dates from the carrier. Your first week's deduction would be different and is listed accordingly.

Total Weekly Deduction

$

I chose to have my pay reduced to pay for my benefits under the Employer-sponsored benefit plans. If there is a change in my cost, the reduction may be adjusted to automatically reflect the change. My compensation shall be reduced accordingly each pay period.

I understand that this Payroll Deduction Authorization shall remain in force until I waive my participation rights or change my level of coverage in any or all of the Employer-sponsored benefit plans in writing to the Human Resource office. I understand that authorized payroll deductions are a requirement for participation in these plans. I will notify the Human Resource office of any coverage changes.

Print Name_____ Signature_____

Date_____

Deduction will start on paycheck dated _____