Payroll Deduction Form

Employee Information

Employee # _____ Name: _____ Dept: _____

SSN: _____ Status: ☐ FT ☐ PT Pay Freq. ☐ BW Scheduled Work Hours _____

Health Insurance and Vision Insurance

Coverage Level

☐ Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family ☐ Employee Domestic ☐ Employee & Family (Domestic

Deduction Change: ☐ Yes ☐ No Reason for Change: _____

Amount of Deduction: _____

Dental Insurance

Coverage Level

☐ Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family ☐ Employee Domestic ☐ Employee & Family (Domestic Partner)

Deduction Change: ☐ Yes ☐ No Reason for Change: _____

Amount of Deduction: _____

Life Insurance

Coverage Level (Employee coverage is required to purchase coverage for spouse and/or children

☐ Employee ☐ Employee AD & D ☐ Spouse ☐ Child(ren)

Coverage Amount _____ Coverage Amount _____ Converge Amount _____ Coverage Amount _____

Deduction Amount _____ Deduction Amount _____ Deduction Amount _____ Deduction Amount _____

Voluntary Short Term Disability

Benefit Amount

☐ $50 ☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $300 ☐ $350 ☐ $400

Amount of Deduction: _____

401(k)

Pre Tax

☐ Amount _____

☐ Percent _____

Post Tax (Roth)

☐ Amount _____

☐ Percent _____

Flexible Spending Account

	PPD Amt	Annual Amt
Medical		
Dependent Care		

Other

Deduction Type: ☐ Gym ☐ Dues ☐ 457

Amount of Deduction: _____ _____ _____

Employee Signature: _____ Date: _____