

Payroll Deduction Form



Employee Information

Employee # _____ Name: _____ Dept: _____

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

Health Insurance

Coverage Level
 Employee Employee & Spouse Employee & Child(ren) Employee & Family Employee & Domestic Partner 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 Partner 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 _____ Coverage 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 _____ Post Tax (Roth) Amount _____
 Percent _____ Percent _____

Flexible Spending Account

Medical _____
Dependent Care _____

Other

Deduction Type: Gym Dues
Amount of Deduction: _____

Employee Signature: _____ Date: _____