Payroll Deduction Authorization

I,_____________________________________(name), Social Security Number or Banner ID __________________

authorize the following deduction(s) from my pay, for electing the following type of coverage:

Employee Classification: ☐ Faculty ☐ Support Staff ☐ Admin/Professional	Premium Choice*: ☐ Pre-Tax ☐ Post-Tax	Coverage Choice*: ☐ Single ☐ 2-person ☐ Family	Benefit Plan*: ☐ Health, Dental, Vision ☐ Dental, Vision only (must provide proof of other health coverage) ☐ Bronze Plan
Deduction *Begin* Pay Date: (semi-monthly)		Employee Amt:	Employer Amt:
Deduction *End* Pay Date:		Employee Amt:	Employer Amt:
Arrears or Pre-Payments:		Employee Amt:	Employer Amt:

*I understand that an amount equal to the total premium contribution for coverage elected will be withheld from my wages, continuing until this agreement is amended or terminated. In the event of a rate change, I authorize a corresponding change in my deduction. I cannot change or revoke my elections prior to the start of a new plan year, unless I have a Change in Status or Other Qualifying Life Event. If employment terminates before my balance is paid in full, the remaining balance will be withheld from my final check.

Signature _______________________________________ Date ____________________

For Human Resources use only	
Benefit Effective Date	
Double Deduct	☐ Hired 1-12 of month
	☐ Entered in BCBSM