BENEFITS DEDUCTION AUTHORIZATION

DATE ______________________

COMPANY NAME ____

EMPLOYEE NAME __________________________________ TITLE ______________________

HEALTH - BENEFITS DEDUCTIONS

Indicate if these deductions are pre-tax or post tax

Group Medical	$____________	☐Pre Tax	☐ Post Tax	____ times per month OR	☐ per paycheck
Vision	$____________	☐Pre Tax	☐ Post Tax	____ times per month OR	☐ per paycheck
Group Dental	$____________	☐Pre Tax	☐ Post Tax	____ times per month OR	☐ per paycheck
401K	$____________	☐Pre Tax	☐ Post Tax	____ times per month OR	☐ per paycheck
Long Term Disability	$____________	☐Pre Tax	☐ Post Tax	____ times per month OR	☐ per paycheck
Short Term Disability	$____________	☐Pre Tax	☐ Post Tax	____ times per month OR	☐ per paycheck
Life Insurance	$____________	☐Pre Tax	☐ Post Tax	____ times per month OR	☐ per paycheck
FSA/HRA	$____________	☐Pre Tax	☐ Post Tax	____ times per month OR	☐ per paycheck
Accident	$____________	☐Pre Tax	☐ Post Tax	____ times per month OR	☐ per paycheck
Other______________	$____________	☐Pre Tax	☐ Post Tax	____ times per month OR	☐ per paycheck

By signing below, I authorize Fourth HR ("Fourth") to make deductions from my pay according to the terms indicated above. These deductions will only be made after all federal and state requirements are satisfied. I allow Fourth to make adjustments to these amounts should I miss a pay period or am unable to make a scheduled payment for any reason. ***I understand and agree with these terms and I have signed this form voluntarily.***

EMPLOYEE SIGNATURE ____ **DATE** ____________

DEDUCTION START DATE ____________________ **DEDUCTION END DATE** ________________

RECEIVED BY ____________________________________ DATE ________________

POSTED BY ____________________________________ DATE ________________

REVIEWED BY ____________________________________ DATE ________________

Special Instructions

____

____