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

_____

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