

Wayne County Voluntary Benefits Program

PAYROLL DEDUCTION AUTHORIZATION

RETURN FORM TO BENEFITS ADMINISTRATION DIVISION
 500 GRISWOLD - 9TH FLR, DETROIT, MI 48226
 PHONE: 313-224-7721 ♦ FAX: 313-967-1228
 EMAIL: BENEFITS@WAYNECOUNTY.COM

Employee ID Number: _____

Employee Name: _____
Last
First
Middle Initial

Daytime Phone: _____ Email : _____

PLAN TYPE	PLAN PROVIDER	DEDUCTION CODE	PLAN EFFECTIVE DATE	START DEDUCT. (Pay Date)	CHANGE DEDUCT. (Pay Date)	STOP DEDUCT. (Pay Date)	DEDUCTION AMT PER PAY (Based on 24 Pays)
Short-Term Disability (VIP)	Humana	INHVDI					
Hospital Indemnity (VIP)	Humana	INHVHI					
Accident Plus Coverage	Humana	INHACC					
Cancer Insurance	Humana	INHCCP					
Critical Illness Advantage Plan	Humana	INHCCI					
Term Life Insurance	The Hartford	INSGLI					
Whole Life Insurance	UNUM	INSWLI					
Identity Theft Protection Plan	New Benefits	INSSIP	5-16-2013	5-17-2013			\$4.48
Prepaid Legal Plan	Legal Shield	INSRLS					
Pet Insurance Plan	VPI	INSPET					
Exec LTD Insurance	UNUM	INSLTD					
Short-Term Disability Insurance	Sun Life	INSSTD	N/A	N/A			
Hospital Indemnity Insurance	Sun Life	INSHOS	N/A	N/A			
Cancer Insurance	Sun Life	INSCNR	N/A	N/A			
Accident Insurance	Sun Life	INSACC	N/A	N/A			
Term Life Insurance	Sun Life	INSPRO	N/A	N/A			
Disability Income Advantage Plan	Humana	INHSTD	N/A	N/A			
Supplemental Health Plan	Humana	INHSHI	N/A	N/A			
OTHER: _____							

I hereby authorize my employer to make initiate or make changes to my payroll deductions for the voluntary benefit programs as indicated above. With regard to deductions taken, I agree to have the amount remitted to the Companies (Plan Providers) as I have indicated above. It is understood that any deduction and remittance shall cease (1) upon termination of my employment, or (2) upon my written notice to my employer's payroll office of the cancellation of this request, or (3) upon termination of the salary deduction agreement between the Companies indicated above and my employer. I further understand that, in the case where a deduction for any premium payment due is not taken in whole in part due to lack of available earnings, it is my responsibility to make arrangements to pay the premiums due and that cancellation of plan benefits may result from a failure to do so. Companies may deduct less than authorized.

Employee Signature: _____ Date: _____

The voluntary benefit programs indicated about have been explained to me and I elect **NOT** to participate

Employee Signature: _____ Date: _____

New enrollments or changes in enrollment will not take effect unless and until approved by an authorized enroller.

Authorized Enroller Signature: _____ Date: _____