



**BENEFITS DEDUCTION AUTHORIZATION**

DATE \_\_\_\_\_  
COMPANY NAME \_\_\_\_\_  
EMPLOYEE NAME \_\_\_\_\_ TITLE \_\_\_\_\_

<b>HEALTH - BENEFITS DEDUCTIONS</b>			
Indicate if these deductions are pre-tax or post tax			
Group Medical	\$ _____	<input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax	_____ times per month OR <input type="checkbox"/> per paycheck
Vision	\$ _____	<input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax	_____ times per month OR <input type="checkbox"/> per paycheck
Group Dental	\$ _____	<input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax	_____ times per month OR <input type="checkbox"/> per paycheck
401K	\$ _____	<input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax	_____ times per month OR <input type="checkbox"/> per paycheck
Long Term Disability	\$ _____	<input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax	_____ times per month OR <input type="checkbox"/> per paycheck
Short Term Disability	\$ _____	<input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax	_____ times per month OR <input type="checkbox"/> per paycheck
Life Insurance	\$ _____	<input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax	_____ times per month OR <input type="checkbox"/> per paycheck
FSA/HRA	\$ _____	<input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax	_____ times per month OR <input type="checkbox"/> per paycheck
Accident	\$ _____	<input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax	_____ times per month OR <input type="checkbox"/> per paycheck
Other _____	\$ _____	<input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax	_____ times per month OR <input type="checkbox"/> per paycheck

*By signing below, I authorize CHOICE HR 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 CHOICE HR 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**

\_\_\_\_\_  
\_\_\_\_\_