

AUTHORIZATION FOR PAYROLL DEDUCTION

DEDUCTION \$ _____ pre-tax AMOUNT: \$ _____ post-tax	Deduction Begins _____ Date (MM/DD/YYYY)	FREQUENCY OF BILLING <input type="checkbox"/> Monthly <input type="checkbox"/> Every two weeks (26 pay periods per year) <input type="checkbox"/> Semi-monthly (24 pay periods per year) <input type="checkbox"/> Four Weeks Per Month (28 Day Group) <input type="checkbox"/> Weekly <input type="checkbox"/> Other _____
EMPLOYEE _____		
EMPLOYEE/PAYROLL # _____	SEC./DEPT. # _____	

I hereby authorize my employer to deduct from my salary until further notice the premium presently payable and which may be hereafter payable for insurance issued or administered by COLONIAL LIFE & ACCIDENT INSURANCE COMPANY and to remit same premium to the above named insurance company.

I understand that premium deduction amounts may change and do hereby consent to such changes without the necessity of additional authorization on my part, verbal or written, provided the insurance company above certifies in writing that the change in premium uniformly affects all members of the class to which I belong.

I agree not to hold my Employer responsible in the event a premium payment is not made when due to the Insurance Company.

_____ Date (MM/DD/YYYY) _____ Phone Number

X _____
Employee Signature

_____ Address

COVERAGES	APPLICANT	SPOUSE	DEPENDENT CHILDREN	TOTAL
ACCIDENT				
LIFE				
SICKNESS				
CANCER				
HOSPITAL INCOME				
INTENSIVE CARE				
OTHER				
DISABILITY				

TOTAL PAYMENT	FIRST DEDUCTION <input type="checkbox"/>	CHANGE IN DEDUCTION <input type="checkbox"/>	\$
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Colonial Life is Not Responsible For Stopping Payroll Deductions.

Return this card to your Payroll Department
 Return this card to Colonial Life