Payroll Deduction Authorization Form

Personal & Confidential

Employee Name:____

Social Security Number:___________________________ Effective Date:___________________________________

Please check Department: ☐ ADM ☐ CDS ☐ EHS ☐ ES ☐ FDD ☐ HS ☐ WIC

Payroll Deductions for Health Insurance

Plan	Tier	**Full Year** Pay Period Deduction (26 pay periods)	Check	**Program Year** Pay Period Deduction (22 pay periods)	Check
SB 25-500	Single	$193.19	☐	$228.31	☐
$25/$40 Copay	Family	$526.80	☐	$622.58	☐
Hybrid 1	Single	$117.59	☐	$138.97	☐
$40/$60 Copay	Family	$336.02	☐	$397.12	☐
Signature 3	Single	$20.69	☐	$24.45	☐
HDHP	Family	$95.53	☐	$112.90	☐

Payroll Deductions for Dental Insurance

Plan	Tier	**Full Year** Pay Period Deduction (26 pay periods)	Check	**Program Year** Pay Period Deduction (22 pay periods)	Check
High	Single	$7.09	☐	$8.38	☐
	Employee & One	$12.00	☐	$14.19	☐
	Family	$14.97	☐	$17.69	☐
Low	Single	$5.94	☐	$7.02	☐
	Employee & One	$10.06	☐	$11.89	☐
	Family	$12.55	☐	$14.83	☐

I hereby authorize CAPCO to make the above deduction from my pay in accordance with the above terms. I understand and agree that I am responsible for satisfying the above amount. I understand and agree the any amount that is due and owing at the time of my termination, regardless of whether my termination was voluntary or not, will be deducted from my last paycheck. This authorizes my employer to retain the entire amount of my last paycheck in compliance with the law. I further understand and agree that deductions will be made after any federal or state requirements as well as for any CAPCO programs in which I have enrolled, for which I am eligible, or to which I have agreed.

Employee Signature:____ Date:____________________