



## EMPLOYEE PAYROLL DEDUCTION AUTHORIZATION

TO: PAYROLL DEPARTMENT \_\_\_\_\_  
Employer Effective Date

FROM: \_\_\_\_\_  
Employee Department

SOCIAL SECURITY NO.: \_\_\_\_\_

Please deduct the amount shown below to pay monthly premiums for the insurance policy I have applied for with US Able.

Such deductions shall cease upon written notice by me of the cancellation of this request or upon notice by you or the Insurance Company that contributions will no longer be deducted from my salary. I understand that premiums may change due to a rate increase or an age change on some coverage I have selected. In this case, a new Employee Payroll Deduction Authorization form will not be required.

I understand that no insurance will take effect until my application is approved by US Able.

	<b>Monthly Premium (if needed)</b>	<b>Amount Deducted Per Pay Period</b>		<b>Increase Per Pay Period</b>	<b>From</b>	<b>To</b>
UL	\$ _____	\$ _____	UL	\$ _____ / \$ _____		
Disability	\$ _____	\$ _____	Disability	\$ _____ / \$ _____		
Cancer	\$ _____	\$ _____	Cancer	\$ _____ / \$ _____		
AD&D	\$ _____	\$ _____	AD&D	\$ _____ / \$ _____		
HIP	\$ _____	\$ _____	HIP	\$ _____ / \$ _____		
CCU/ICU	\$ _____	\$ _____	CCU/ICU	\$ _____ / \$ _____		
VGL or VEL	\$ _____	\$ _____	VGL or VEL	\$ _____ / \$ _____		
Accident	\$ _____	\$ _____	Accident	\$ _____ / \$ _____		
Heart/Stroke	\$ _____	\$ _____	Heart/Stroke	\$ _____ / \$ _____		
	\$ _____	\$ _____		\$ _____ / \$ _____		

weekly     
  bi-weekly     
  monthly     
  semi-monthly

I wish to drop the following insurance \_\_\_\_\_  
Company Type  
 amount \_\_\_\_\_.

\_\_\_\_\_  
 Signature of Employee

\_\_\_\_\_  
 Date Signed

**For Universal Life Only**  
 Complete if Applicant is not the Employee

Name of Applicant	Premium Amount

The above names will be listed on bill with employee applicable.