PAYROLL DEDUCTION AUTHORIZATION FORM

Please make a copy of this SIGNED AND APPROVED form and bring it into Beacon Health for enrollment into your membership. The original copy stays with your payroll department to start your payroll deduction.

NAME (PLEASE PRINT): _____ DATE OF BIRTH: _____

FIRST MIDDLE INITIAL LAST

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL: _____

I HEREBY AUTHORIZE **(MY EMPLOYER):** _____

TO DEDUCT $ _____ * (AMOUNT EACH PAY PERIOD)

* Amounts will vary based on company pay cycles and subsidies when available.

TO BE USED FOR : A BEACON HEALTH MEMBERSHIP (PLEASE CHECK TYIPE BELOW):

- ◯ HOUSEHOLD (2 ADULTS & THEIR DEPENDENTS)
- ◯ ADULT (AGE 18+)
- ◯ ONE ADULT HOUSEHOLD (1 ADULT & THEIR DEPENDENTS)

◯ (PLEASE CHECK) By checking this box I understand that my Beacon Health membership rates may change, and my payroll deduction will adjust accordingly until I notify my Human Resources Department in writing to discontinue deductions. I can revoke this payroll deduction agreement at any time and agree to notify Beacon Health and my employer if I choose to do so. I understand that if my payroll deduction stops and I have not completed my 12-month membership agreement, I will make arrangements with Beacon Health to continue my membership payments.

EFFECTIVE DATE (DATE PAYROLL DEDUCTION BEGINS): _____

EMPLOYEE SIGNATURE: _____ DATE: _____

HR / PAYROLL SIGNATURE: _____ DATE: _____

BOTH SIGNATURES ARE REQUIRED TO BEGIN MEMBERSHIP