Case Name:	Representative:	

Employee Name and Work Department –

Payroll Deduction Authorization & Memorandum of Understanding

Product	Insured (*EE, SP, CH, FAM)	Annual Premium	Deduction Mode (# paychecks)	Deduction Amount
Cancer Expense				
Disability Plan				
Disability Plan				
Disability Plan				
Permanent Life				
Permanent Life				
Permanent Life				
Dental				

I understand that all coverage is subject to underwriting and that my application can be declined.

I understand that the proposed issue date is: _____ _____

I authorize my employer to make the deductions, as listed above from my earnings.

_____

Signature of Employee Date

****

Waiver

I have been offered the opportunity to participate in this voluntary supplemental insurance benefit plan and I have declined.

I understand that if I should later desire to apply, evidence of insurability may be required.

_____

Signature of Employee Date

*(EE=Employee, SP=Spouse, CH=Child, FAM=Family)