PAYROLL DEDUCTION AGREEMENT FOR VOLUNTARY EMPLOYEE PAID PROGRAMS

This section to be completed by the employee

Please type or print legibly (illegible forms will be returned)

EMPLOYEE MUNIS#: ______________________ **OFFICE/AGENCY:** ________________

EMPLOYEE NAME: ______________________ **SSN: XXX-XX-** ________

I hereby certify that I have reviewed and understand the information about the voluntary employee paid program(s) available below. I have reviewed the information and coverage levels for myself and my eligible dependents (if any). I hereby certify eligibility and the accuracy of the program coverage(s). I understand that the pre-tax or post-tax payroll deduction amount will be automatically adjusted in the event of any change in rates or any change in program coverage level(s).

Select	Type	Pre/Post Tax	Deduction Code	Pay Cycle(s)
	Supplemental Life	Post	2360	1,2
	Short-Term Disability	Post	2339	1,2
	Long-Term Disability	Post	2339	1,2
	Aflac Pre-Tax	Pre	2000	1,2,3
	Aflact Post-Tax	Post	2370	1,2,3
	Health Care Flexible Spending Account (HCFSA)	Pre	2001	1,2
	Dependent Care Flexible Spending Account (DCFSA)	Pre	2002	1,2

The pre-tax and/or post-tax payroll deduction(s) will be taken from the pay cycles noted above. It is my responsibility to review my paycheck stub to ensure the proper amount was deducted. In the event that the payroll deduction was not processed, I understand that I am personally responsible for paying the payroll deduction amount to the **insurance company** or the Benefits Office directly unless instructed otherwise or risk benefit termination.

I understand that pre-tax payroll deductions are irrevocable unless there is a qualifying life event or during the annual open enrollment period. The post-tax payroll deductions are revocable upon written notice to my agency Payroll Officer or the Benefits Office. This payroll deduction agreement for employee paid premiums covers both pre-tax and post-tax payroll deductions for the voluntary programs. I further understand that if I cancel coverage for either a pre-tax or post-tax program, I will not be eligible to re-enroll until a) new hire status, b) qualifying life event occurs, or c) during the annual Open Enrollment period as defined by the Franklin County Commissioner's Benefits Office.

Signature: ____ **Date**: ____________________

(For Agency Use Only)

MUNIS Deduction Code(s): ______________ **Effective Date**: ______________________