

PAYROLL DEDUCTION AUTHORIZATION

(PLEASE TYPE OR PRINT)

Employee: _____
(Last) (First) (Middle)

Social Security # _____

Employee # _____

Initial Deduction Change Deduction Stop Deduction

Date of First Deduction _____ Total Per Pay Period _____

Weekly (52) Biweekly (26) Semimonthly (24) Monthly (12)

Deductions per Product

\$ _____ Disability
\$ _____ Hospital Indemnity
\$ _____ Cancer
\$ _____ Life
\$ _____ Other

EMPLOYER NAME: _____

I hereby authorize my employer to deduct from my pay each pay period the amount shown above and to remit that amount to Professional Insurance Company. It is understood that this deduction and remittance shall cease (1) upon termination of my employment, or (2) upon my written notice to my employer of the cancellation of this request, or (3) upon termination of the salary deduction agreement between Professional Insurance Company and my employer.

Signature of Employee: _____

Date Signed: _____

The Payroll Deduction Plan offered by Professional Insurance Company has been explained to me and I elect not to participate.

Signature of Employee: _____

Date Signed: _____