



**PAYROLL DEDUCTION AGREEMENT FOR
SUPPLEMENTAL LIFE INSURANCE PREMIUMS
SHORT-TERM AND/OR LONG-TERM DISABILITY PREMIUMS**

This section to be completed by the employee

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

EMPLOYEE #: _____ **AGENCY:** _____

EMPLOYEE NAME: _____ **SSN: XXX-XX-** _____

I hereby certify that I have reviewed and understand the information about the voluntary insurance programs available below. I have reviewed the personal information and coverage levels for myself, my dependents (if any), and/or myself and my domestic partner (if any). I hereby certify the accuracy. I understand that the deduction amount will be automatically adjusted in the event of any change in rates or any change in coverage.

Select	Type	Pre/Post Tax	Deduction Code	Cycle(s)
	Supplemental Life (Standard Insurance Co.)	Post	2360	1
	Short-Term or Long-Term Disability (MetLife)	Post	2339	1,2

The money 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. If the employee is not receiving a paycheck or does not have enough gross pay to cover voluntary deductions for the above premiums, the employee must make arrangements to remit premium payment(s) to the Franklin County Benefits Office.

I understand that this deduction agreement for voluntary insurance premiums is revocable upon written notice to my agency Payroll Officer.

Signature: _____ **Date:** _____

(For Agency Use Only)

MUNIS Deduction Code(s): _____ **Effective Date:** _____