

Allegheny College
Payroll Authorization Form - Dental/Vision Coverage
Current Employee

Name: _____

Social Security Number: _____

Marital Status (circle one): _____ Single _____ Married _____ Partner # of Dependents _____

Dental Plan (check plan and classification):

_____ Elect/Change Coverage (check classification below also)	Per Pay Contribution Level	
	Paid Bi-Weekly	Paid Monthly
_____ Single	\$12.40	\$24.80
_____ Employee & Spouse/Partner	24.78	49.55
_____ Employee & Child	26.05	52.09
_____ Employee & Children	26.05	52.09
_____ Family	37.17	74.34
_____ Cancel Coverage		

Vision Plan (check plan and classification):

_____ Elect/Change Coverage (check classification below also)	Per Pay Contribution Level	
	Paid Bi-Weekly	Paid Monthly
_____ Single	\$3.75	\$7.50
_____ Employee & Spouse/Partner	6.78	13.55
_____ Employee & Child	6.78	13.55
_____ Employee & Children	9.18	18.35
_____ Family	9.18	18.35
_____ Cancel Coverage		

Salary Reduction Agreement (check appropriate arrangement):

- By checking this line, I authorize Allegheny College to reduce my future earnings by the contribution level chosen above on a pre-tax basis effective _____.
- By checking this line, I authorize Allegheny College to reduce my future earnings by the contribution level chosen above on a post-tax basis _____.

I understand that the choices made above will remain in effect for at least two years. If I have a change in family or employment status, I may be able to change the choices made by completing a new payroll authorization form within 30 days of the date of the status change. I also understand that adding dependents to the coverage at a later date other than as a result of a change in family status (late enrollment) will require that I will be subject to the underwriting requirements of the carrier before the coverage can be provided.

Signature: _____

Date: _____