

**Diocese of Gary**  
**Authorization for Dental Payroll Deduction Form 2011-2012**

Please be advised that I wish to participate in the Guardian First Commonwealth Voluntary Dental Insurance with the coverage type indicated below:

Please check one:

Dental Network Plan:	Single _____ \$15.00 monthly	Single +1 _____ \$30.00 monthly	Family _____ \$39.00 monthly
PPO Plan:	Single _____ \$27.00 monthly	Single +1 _____ \$53.00 monthly	Family _____ \$81.00 monthly

I authorize a monthly payroll deduction from my salary in the amount indicated above. I understand that the monthly deduction will continue for a minimum of 12 (twelve) months, or until the next open enrollment period. **The coverage will be continuous, unless I otherwise notify the Diocese of Gary Benefits Office in writing of my wish to drop the coverage during the next annual open enrollment period.**

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Location Parish, School or Institution Name)

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