

DIOCESE OF GARY

Dependent Health Insurance Premium

Authorization for Payroll Deduction

Please be advised that I wish to enroll my dependents in the Diocese of Gary Health Care Plan. I understand that my employer does not pay dependent coverage.

I authorize a monthly payroll deduction to be made from my salary in the amount indicated below as payment for health insurance coverage for my dependents. The coverage will be continuous, unless I otherwise notify the Diocese of Gary Benefits Office in writing of my wish to drop the coverage. I understand the premium is subject to increases without notification.

Number of dependents enrolled _____

Names: _____

Current monthly payroll deduction is: \$ _____

Employee's Signature

Date

Printed Name

Location
(Parish, School or Institution Name)