DIOCESE OF GARY

Dependent Health Insurance Premium

Authorization for Payroll Deduction

Please be advised that I wish to enroll my dependent(s) 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, in writing, the Diocese of Gary Benefits Office 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)**