Insurance Payroll Deduction Authorization Form

(SAINT JOHN NEUMANN)

Plan Year July 1, 2018-June 30, 2019

Employee Name: _____ Coverage Effective Date: _____

Medical

Complete this section if you are electing medical coverage:

	Bi-Weekly Deduction		
Plan	Employee Only	Emp/spouse	Parent/ child (ren) Family
HMO	$ 57.05	$ 137.10	$ 250.00

Dental

Complete this section if you are electing dental coverage:

		Bi-Weekly Deduction		
Plan	Employee Only	Emp/spouse	Employee/child(ren)	Family
Delta Dental	$ 18.60	$ 34.08	$ 30.45	$ 47.42

Vision

Complete this section if you are electing vision coverage:

	Bi-Weekly Deduction		
Plan	Employee Only	Emp/spouse – emp child(ren)	Family
Davis Vision	$ 2.69	$ 6.99	$ 6.99

I am aware of and authorize the Diocese of Scranton to deduct from my paycheck the pre-tax amount(s) for the coverage(s) checked above. I elect to receive such coverage under the Diocese of Scranton Highmark Plan. If the diocese incurs changes in premiums, I will receive notice of any change and my deduction with automatically be adjusted. I understand that I will not be able to change my coverage until the next open enrollment period or within 30 days of a qualifying life event.

_____ _____

Employee Signature Date