



Employee Health & Dental Deduction Form

Client Time Sensitive Instructions:

- Please complete this form in order to change health and/or dental deductions and return it to your Client Service Representative prior to your first payroll run after the effective date.
- To ensure accuracy, we are unable to process enrollments and changes without this completed form. Please complete the information below and see specific instructions for Part I and/or Part II.

Client Number: _____

Company Name: _____

Client Service Representative: _____

Is your Health and/or Dental Plan Administered through the USA Payroll Agency?

Yes - If Yes, please proceed to Part II.

No - If No, please complete Part I and II.

Part I: This section of the form must be completed for any enrollments and/or changes to health/dental coverage.

Name of Plan Carrier: _____

Effective Date of Changes: _____

Single Rate for Plan: _____

2 Person Rate for Plan: _____

Family No Spouse Rate for Plan: _____

Family EE Plus Child/Children Rate for Plan: _____

Are the Deduction Amounts Pre-Taxed (Pre-Taxed Plans Require Section 125)? Yes No

The Deduction Amounts provided are: Per Pay Period Amounts Monthly Amounts

Are any Employer Contributions being made to the plan? Yes No

If Yes, please provide the Employer Contribution Amount _____ OR Percentage _____

Note: As the employer, if you are paying 100% of the contributions, then the information below is not needed.

Part II: This section of the form must be completed for any changes, additions, and/or cancellations. The only time this section would not be completed is if the contributions are 100% employer paid.

Participant Name:	Amount of Deduction:	Type of Deduction Health OR Dental (Check One)	If discontinuing the deduction, provide the effective date of cancellation:
Example: John Doe	\$38.92	<input checked="" type="checkbox"/> Health <input type="checkbox"/> Dental	
Example: John Doe	\$8.81	<input type="checkbox"/> Health <input checked="" type="checkbox"/> Dental	
		<input type="checkbox"/> Health <input type="checkbox"/> Dental	
		<input type="checkbox"/> Health <input type="checkbox"/> Dental	
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		<input type="checkbox"/> Health <input type="checkbox"/> Dental	

Client Signature: _____

Date: ___/___/___ Rev 2/19