Voluntary Life Insurance for _____
Your Employer Name

AUTHORIZATION FOR PAYROLL DEDUCTION

PLEASE PRINT USING CAPITAL LETTERS

Employee Unit # _____ Social Security # _____ Work Telephone Extension _____

Employee Name: _____
Last *First* *MI*

Spouse's Name if the Insured: _____
Last *First* *MI*

Payroll: ❑ Weekly ❑ Monthly ❑ Bi-Weekly ❑ Semi-Monthly

Deduction Amount: _____

AUTHORIZATION FOR DEDUCTION

I authorize my employer to deduct each pay period the insurance premium for the MHA Voluntary Life Insurance I have selected. Such deduction shall continue until (a) termination of my employment, (b) the month in which written notice from me is received by Payroll at least seven (7) days prior thereto, or (c) termination of this authorization arrangement by my employer.

APPLICATION ONLY	*Employee Signature*	*Date*
CANCELLATION ONLY	*Employee Signature*	*Date*

ADMINISTRATOR USE ONLY - DO NOT COMPLETE THIS SECTION

Total Deduction Amount _____ Effective Date _____ Cancel ❑

• THIS FORM MUST BE SIGNED BY THE EMPLOYEE •

Mail this form along with your completed application to:

MHA Solutions
INSURANCE & BENEFITS

Patti Cheever
Account Specialist
500 District Avenue
Burlington, MA 01803