American Payroll and Benefits I, LLC
PO Box 189 Ocala, FL 34478
Phone: 352-624-1999 Fax: 352-342-9356

Payroll Deduction Authorization

Name: ____ Soc. Sec. #: _____________________

Client Name: ____

Type of Deduction (IE Health Ins, Dental, Loan)	Check Date to Commence	Total Amount of Deduction Enter Total Dollar Amount **OR** If Ongoing - Leave Blank	Amount Per Pay Period	Pre Tax	Post Tax
				(Select One)	

* This application for coverage has been submitted to Colonial for review. If the application is approved you will receive a policy. Coverage under the policy will not be effective until the policy/certificate is issued and the first premium is paid. If the application is declined, you will be notified by Colonial. I understand that I am allowed to reduce my salary for the purchase of qualified benefits as part of a flexible benefits plan ("plan") under Section 125 of the Internal Revenue Code. I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for this coverage. I further authorize future adjustment in the amount of the salary reduction in the event that the cost of coverage in any program selected for "Pre-Tax" is changed during the plan year. I further authorize a payroll deduction for the amount necessary to pay for the coverage selected for "Post-Tax", if any. I further authorize the allocation of funds provided by my employer for the purchase of qualified benefits, if any. Additional Terms: As required by the Internal Revenue Service (IRS) regulations, contributions under the plan will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of, and consistent with, a change in status (e.g. marriage, divorce, death, and termination of employment of spouse) or as otherwise allowed under IRS regulations. I understand that the insurance claim payments under certain coverages may be subject to federal and state taxes when the premium is paid by salary reductions or employer contributions. I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan. In most instances an application for insurance must also be completed. I have read and agree to all terms listed above.

I hereby authorize American Payroll and Benefits I, LLC (APBI) to make the above deductions from my pay in accordance with the above terms. I understand and agree that I am responsible for satisfying the above amounts. I further understand and agree that deductions will be made after any federal or state requirements, if applicable, as well as for any APBI or ______________________ (Client Name) programs in which I have enrolled, for which I am eligible, or to which I have agreed.

____ ____________________

Employee Signature Date

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