USA PAYROLL

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 Payroll Specialist 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: _____**

Payroll Specialist: _____

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

☐ **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	X Health ☐ Dental	
Example: John Doe	$8.81	☐ Health X Dental	
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Client Signature: _____ Date: ___/____/____ Rev 11/14

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