Allegheny College

Payroll Authorization Form – Medical Coverage
(Current Employee)

Name: _____

Social Security Number: _____

Marital Status: _____Single _____Married _____Partner # of Dependents_____

_____ **Elect or Change Coverage** **OR** _____ **Cancel Coverage**
(Check classification below)

_____ Single*
_____ Employee & Child*
_____ Employee & Spouse/Partner*
_____ Family*

The cost to the employee for the medical coverage will be at a percent of premium based on the attached schedule.

Salary Reduction Agreement (check appropriate arrangement):

_____ By checking this line, I authorize Allegheny College to reduce my future earnings on a pre-tax basis, effective _____.

_____ By checking this line, I authorize Allegheny College to reduce my future earnings on a post-tax basis, effective _____.

If my dependents or I have a change in family or employment status, I may be able to change the choices made by completing a new enrollment form and payroll authorization form within 30 days of the date of the status change. I also understand that adding dependents to the coverage at a later date other than as a result of a change in family status (late enrollment) will require that I will be subject to the underwriting requirements of the carrier before the coverage can be provided, and the coverage can only be effective as of the next July 1st.

Signature: _____ **Date:** _____