American Benefit Services, LLC
P.O. Box 1635
Irmo, SC 29063
803-407-0133 or 866-826-6554

Payroll Deduction Authorization

____
Group Name

Employee Name: ______________________________ DOB: __________

Address: ____

City: __________________________________ State / Zip: ______________

SS#: ________________________________ DOH: ______________________

Product	Before (Pre) Tax	After (Post) Tax
Medical Insurance		
Dental Insurance		
Term Life Insurance		
Universal Life Insurance		
Short Term Disability		
Cancer Insurance		
Accident Insurance		
Vision Insurance		
Medical Reimbursement Plan (FSA)		
Dependent Care Reimbursement (FSA)		
Other		
Other		
Payroll Deduction Totals		

Payroll Frequency:

Weekly Bi-Weekly Semi-Monthly Monthly Other____________

I understand that by participating in this plan:

- My Social Security benefits may be slightly reduced as a result of my elections
- My annual withholding (W-2) form will reflect my reduced taxable income
- I cannot change this election during the plan year unless there has been a significant increase in cost, or a family status change as outlined in my Summary Plan Description
- My employer may cancel this election, if necessary, to comply with the provisions of the Internal Revenue Code
- My portion of the cost of the Benefit Plans paid with pre-tax dollars will automatically increase or decrease, as the case may be, to reflect the change in the cost of the benefits

_____ I authorize the above amounts to be payroll deducted each pay period.

_____ I have read the above terms and conditions, and would like to participate in the Section 125 plan.

_____ I do not wish to participate in the Section 125 plan.

_____________________________________ ________________________
Signature Date