WEA Member Benefits™ TRUST Advantage™

P.O. Box 7893 • Madison, WI 53707-7893 1-800-279-4010 Fax: (608) 223-9700

Payroll Deduction Authorization

Important: Please complete this form and return it to your payroll office as soon as possible.

1. Employee Information

Last Name ____ First ____ M.I. ____ Social Security Number ____

Address ____ Evening Phone ____

City ____ State ____ ZIP ____ Work Phone ____

2. Employee Authorization

I authorize my Employer to deduct insurance premiums and/or IRA contributions from my pay in the amounts necessary and to forward it to WEA Member Benefits, subject to the terms and conditions stated in this Authorization.

I understand that if I make any changes to my policy(ies) that I must make them through WEA Member Benefits and not through my employer. If I make any changes that affect the amount to be withheld, the Employer will adjust the payroll deduction amounts accordingly (WEA Member Benefits does not adjust payroll deductions–only the Employer does). I understand that it is the Employer's obligation to deduct and transmit funds to WEA Member Benefits on my behalf.

I understand that my participation in *Trust Advantage* requires the Employer to supply payroll and financial information to WEA Member Benefits.

I understand that if my net pay is not sufficient to fully cover any deduction, I am responsible to make timely payment on my own. In the event I terminate employment with this Employer for any reason, cancel my policy(ies), or have an unpaid balance remaining on any policy at the end of its term, I understand that I am responsible for paying any premium that is due. This amount will either be billed to me separately and paid directly to the insurer or be paid through an additional payroll deduction. If full payment is not made timely, my insurance policy is subject to cancellation.

I understand that a delay in returning this Authorization to the Employer could delay payroll deductions, which may result in larger deductions than anticipated for insurance products or a delay in contributions to the IRA I have established.

This Authorization shall remain in effect until I notify WEA Member Benefits of my desire to terminate this Authorization.

3. Employer Approval

The Employer will provide a monthly remittance report and any amount due will be collected via ACH from the school's account.

Employer Rep. Name ____ District/Employer____

Signature ____ Date ____