



Discover ★ Enjoy ★ Celebrate!

P.O. BOX 178 • 114 WOODHULL STREET • LAINGSBURG, MICHIGAN 48848-0178
PHONE (517)651-5374 • FAX (517) 651-5604 • WWW.LAINGSBURG.US

Employee Payroll Deduction Authorization Form

Employee Name: _____ SSN: _____ - _____ - _____

Deduction Effective Date: _____

Payroll Deductions:

MERS Health Care Savings Program (Min \$2.50, Max \$500.00) \$ _____

I agree that my gross pay will be reduced by the amount of my deduction as checked and indicated above. In the event of a deduction change during the year, my employer is authorized to deduct the new amount from my pay.

In the event a new Employee Deduction Authorization Form is not executed on or before the next year-end, this form shall be deemed to continue in force for the next succeeding year.

Employee Signature: _____ Date: _____

NOTE: If form is not returned, the minimum of \$2.50 will be deducted from employee's pay.