2018 TWU-ATD MEMBERS VOLUNTARY INSURANCE PROGRAM

PAYROLL DEDUCTION AUTHORIZATION

(ALL FIELDS MUST BE COMPLETED IN FULL)

EMPLOYEE NAME:_____ S.S. NUMBER (Please write in FULL #):_____

ADDRESS (in full):_____

EMPLOYEE NUMBER:_____ ENROLLER NAME_____

TYPE OF DEDUCTION:_____ PHONE # _____

NEW ENROLLMENT ( ) CHANGE ( ) WEEKLY PREMIUM:$_____ BI-WEEKLY PREMIUM:$_____

To my employer (herein called THE COMPANY): I hereby voluntarily authorize my employer to deduct from any paycheck which may be due to me each week the amount shown above and to pay the premium on any of the following benefits if elected:

Products	Weekly deductions
Voluntary Term Life Insurance issued by Lincoln Financial	
Voluntary Group Accident insurance issued by Lincoln Financial	
Whole Life insurance issued by UNUM	
Voluntary Group Critical Illness insurance issued by Lincoln Financial	
Short Term Disability Insurance issued by The Hartford Insurance Company (TWU Sponsored)	
Long Term Disability Insurance (TWU Sponsored)	

I understand that, if there are any problems with my deductions, that my employer will make the deductions authorized only when I have sufficient pay to cover the deduction in full and in accordance with all other details as may be agreed upon with my employer acting for itself and me. Such deductions shall continue until termination of my employment or written notice by me requesting cancellation of this order from THE COMPANY. Any missed deductions will be made up on a direct payment basis. I understand that my employer is making these deductions as an accommodation for me and THE COMPANY and that my employer shall have no liability with respect to these deductions or the insurance offered by THE COMPANY or any matter related to such insurance. I understand that if I have any claim against my employer with respect hereto, my sole remedy shall be payment by my employer to THE COMPANY or its designee of any amounts my employer may have failed to remit to THE COMPANY or its designee, provided that, if said failure to remit is due to underdeductions, my employer is able to effect a deduction of the full amount underdeducted, or in the event of an overdeduction, payment by my employer to me of the amount of such excess. I hereby release my employer from all other liability to me, my assigns, heirs or beneficiaries with respect to the deductions, THE COMPANY's insurance, any benefits paid thereunder, or any matter related hereto.

Date: _____ Employee Signature:_____