

Payroll Deduction Request Form

I, _____, do hereby agree to have the following deductions from my Ste. Genevieve County Ambulance District paycheck.

Please check the box for deductions requested.

Item	Amount	Frequency
<input type="checkbox"/> <u>Flower Fund</u>	_____ \$10.00	<u>1st & 2nd pay every month</u>
<input type="checkbox"/> <u>Union Dues</u>	_____ \$24.50	<u>1st & 2nd pay every month</u>
<input type="checkbox"/> <u>Retirement</u> District matches up to 5% Of your salary	_____ %	<u>Every pay period</u>
<input type="checkbox"/> <u>Health Insurance</u> Child or Family Coverage	_____	<u>1st & 2nd pay every month</u>
<input type="checkbox"/> <u>AFLAC Insurance</u> Supplemental Premiums	_____	<u>Every pay period</u>
<input type="checkbox"/> <u>Child Support</u> As court ordered	_____	<u>Every pay period</u>
<input type="checkbox"/> <u>Other Garnishments</u> As Court ordered	_____	<u>Every pay period</u>
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____

Employee Signature _____ Date _____

**\$23.08 per pay period insurance benefit available paid by the District for those wishing supplemental AFLAC insurance or to be applied toward child/family health insurance. If you do not sign up for extra insurance, you do not receive the \$23.08 benefit.