Single Payroll Deduction Contribution Form for Family Health Care Employees

Full Name: _____ Social Security #_____

Job Title: _____ Department: _____

Location Address: Home Address:

_____ _____

_____ _____

Work Phone #:_____ Home Phone #:_____

I wish to make the following contribution. I understand that the total designated amount will be deducted from my paycheck.

Please deduct the following amount:

$500 ( ) $250 ( ) $100 ( ) $50 ( ) $25 ( ) Other $_____

From the pay period of:

12/25/2014 ( ) 1/8/2015 ( ) 1/22/2015 ( )

I authorize BFHC to deduct the amount indicated from my pay check. Should I leave the employment of BFHC prior to the selected pay period, the contribution will be deducted from my final check.

Signature: _____ Date: _____