FBMC
BENEFITS MANAGEMENT

Mail Slot #37, P.O. Box 1878, Tallahassee FL 32302-1878
Fax 850-514-5803 • Phone 800-872-0345

Post-Tax Salary Deduction Authorization

Commonwealth of Virginia Department of Accounts

This multiple use form can be used to authorize new insurance deductions, certify existing benefits and report changes to current deductions, authorize deductions of administration fees, and/or cancel insurance deductions.

Date: _____ Provider Company: _____

Agent Code: _____

Agent Name & #: _____

Agent Phone#: _____

In order for this form to be processed timely, the form must be completed with all requested information. Failure to complete this form will delay the deduction effective date. This form is due to FBMC 8 workdays prior to the payroll effective date.

Provider Office Use Only

Authorized by: _____

Phone Number: _____

Fax Number: _____

Policy Effective Date: _____

Section 1: Participant Information – All employees must complete this section in its entirety.

First Name	MI	Last Name		
Home Address		City	State	Zip
Home Phone #	Work Phone #	Agency Name	Agency Code#	
Birth Date	Date of Hire	# Pay Periods	Social Security #	Employee ID #

Section 2: Complete this section to add, change or delete payroll deductions. Check the box If an employee has more than one policy with a provider and is adding or deleting a policy this section must be completed. for each policy number you are updating.

Add	Change	Delete	Benefit	Policy Number	Monthly Deduction	Per Payroll Deduction	Employee Paid Fee	Effective Date
❑	❑	❑						
❑	❑	❑						
❑	❑	❑						
❑	❑	❑						
❑	❑	❑						
❑	❑	❑						
❑	❑	❑						
❑	❑	❑						
❑	❑	❑						
❑	❑	❑						

I authorize the post-tax salary deductions to be deducted from my net pay each payday and forwarded to FBMC for transfer to the above Provider company. I further acknowledge and authorize the deduction of the stated administration fees as payment for this service. I authorize deduction rate increases or changes as requested by the Provider in accordance with the terms and conditions of my policies. I acknowledge that any or all of the above deductions can be terminated at any time by my written notification to FBMC subject to the terms of the cancellation clause of the policy.

I certify that benefit deduction(s) for this provider were previously authorized and in effect as of_____ (date). The new Post-tax salary deductions will continue to be deducted from my net pay each payday and forwarded to FBMC for transfer to the above Provider companies. I further acknowledge and authorize the deduction of the stated administration fees as payment for this service. I authorize deduction rate increases or changes as requested by the vendor in accordance with the terms and conditions of my policies. I acknowledge that any or all of the above deductions can be terminated at any time by my written notification, subject to the terms of the cancellation clause of the policy.

If deleting, please cancel the post salary deduction(s) for this/these benefit(s) effective _____ (pay-date). I acknowledge the terms of the cancellation clause apply.

Total Deduction Amount $ _____

Participant Signature Date

Total Fees $ _____

Provider Representative Signature Date

Please make a copy of this form for your records.