Santa Monica UNITE HERE Health Benefit Trust Fund

PAYROLL DEDUCTION AUTHORIZATION FORM

INSTRUCTIONS: This form must be completed and returned to the Administrative Office to authorize your Employer to deduct your monthly Employee Premium Contribution from your paycheck. Return the completed form to: **Santa Monica UNITE HERE Health Benefit Trust Fund, c/o Benefit Programs Administration, 1200 Wilshire Blvd., Fifth Floor, Los Angeles, CA 90017-1906.**

PARTICIPANT'S INFORMATION:

Last Name	First Name	M.I.	Date of Birth	Social Security Number
Mailing Address	City	State	Zip Code	Home Phone/Cell Phone Number
Name of Participant's Employer:				

EMPLOYEE PREMIUM CONTRIBUTION AND PAYROLL DEDUCTION AUTHORIZATION:

I hereby authorize my Employer to withhold from my paycheck the monthly premium amount required for the medical coverage that I have selected, and to pay this amount directly to the Santa Monica UNITE HERE Health Benefit Trust Fund (the "Fund"), as follows:

Hotel Plan:

☐ $20.00 per month for Kaiser

In addition, if there is a change to the amount of the monthly Employee Premium Contribution required to maintain my coverage, this authorization will remain in effect, and my Employer is authorized to deduct the amount necessary to maintain the coverage that I selected. I understand that the Administrative Office will give me at least 30 days advance written notice of a change to the monthly Employee Premium Contribution for my coverage.

- I understand that payroll deductions will be taken in advance of the month of coverage.
- I understand that if my Employer does not deduct the appropriate amount from my paycheck, I will be billed for the portion of the monthly Employee Premium Contribution that is owed, and that I must make full payment to the Administrative Office by the due date indicated on the bill or I will lose coverage.
- I understand that in order to maintain my coverage, I must continue to satisfy the Fund's eligibility rules by working the Minimum Required Hours each month, and I must pay my monthly Employee Premium Contribution. I may revoke this authorization and reject coverage by providing written notice to the Administrative Office.

PARTICIPANT'S SIGNATURE: Please Sign and Date Your Authorization Here.

I hereby authorize my Employer to deduct my monthly Employee Premium Contribution, as described above. I certify that the information above is true and correct to the best of my knowledge.

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Signature **Date**