DJR, Inc. dba Encore Mechanical

ENCORE MECHANICAL

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TACLA27439E | TACLA09784E

Authorization for Voluntary Payroll Deduction - Medical, Dental, Vision

I, _____ (print full name) hereby authorize Encore Mechanical to deduct from my wages for benefit premiums as indicated below on a weekly schedule until term of insurance has ended. In the event my employment ends for any reason before the final deduction is made, the remaining monthly premium balance will be deducted from my final wages.

Address:

SSN: DoB:

Medical - ***Primary Care Provider Name/ID# (Req'd for coverage):***

- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Child(ren)
- ☐ Employee & Family
- ☐ *I WAIVE MEDICAL COVERAGE*

Dental -

- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Child(ren)
- ☐ Employee & Family
- ☐ I WAIVE DENTAL COVERAGE

Vision -

- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Child(ren)
- ☐ Employee & Family
- ☐ I WAIVE VISION COVERAGE

Spouse Name: SSN: DOB:

Child Name: SSN: DOB:

Child Name: SSN: DOB:

Child Name: SSN: DOB:

This agreement will remain in effect until Encore Mechanical receives payment of premiuim in full.

I understand that if Encore Mechanical does not receive this form completed and signed within 3o days of employment, all coverage will be waived by default.

Authorized Signature (Primary): _____ Date: