PAYROLL DEDUCTION AUTHORITY

CSEA, Inc./Local 1000, AFSCME, AFL-CIO
143 Washington Ave., Box 7125, Capitol Station, Albany, NY 12224

Must be Completed if Applying for Coverage.

TO THE FISCAL OR PAYROLL OFFICER OF MY EMPLOYER:

I am a member of CSEA and hereby authorize you to deduct from my salary each payroll period the necessary amounts for payment of (check applicable boxes, if any).

❑ **TERM LIFE INSURANCE** ❑ **PERMANENT LIFE INSURANCE** ❑ **DISABILITY INCOME INSURANCE**
❑ **PERSONAL LINES INSURANCE** ❑ **CRITICAL ILLNESS INSURANCE**

Signature:_____ **Date:** _____

(PLEASE PRINT)
❑ Mr.
❑ Mrs.
❑ Ms.
❑ Miss

First Middle Last

Name of CSEA Local

Agency # (if any) Payroll Item # Social Security #

This space for CSEA office use only