



CITY OF FULLERTON PAYROLL DEDUCTION AUTHORIZATION FORM

Effective: _____

BARG UNIT: _____

NAME: _____ EMP #: _____ DIV #: _____

Start: ___/___/___ **OPT-OUT YES / NO** HEALTH Code _____ Pay Period Amount: _____

Stop: ___/___/___ **SPIL YES / NO** DENTAL Code _____ Pay Period Amount: _____

VISION Code _____ Pay Period Amount: _____

By signing, I authorize the City of Fullerton to make the noted payroll deduction(s) on this form.

VOL LIFE Code 2165 Pay Period Amount: _____

► Employee Signature: _____ Date: _____

<u>Code</u>	<u>Deduction Name</u>
2106	Cigna PPO / HSA
2111	Cigna HMO – <i>Full Network</i>
2112	Cigna HMO – <i>Select Network</i>
2113	Cigna Minimum Value Plan
2115	Kaiser HMO
2118	CalPERS Insurance (FIRE)
2135	Delta Dental PPO
2140	Delta Dental HMO
2145	Vision Insurance (VSP)
2165	Voluntary/Supplemental Life

<u>Code</u>	<u>Deduction Name</u>
2715	FFA Dues
2720	FMEF Dues
2725	FPAL
2730	FPOA Dues
2735	FPOA - PAC
2745	FMA Dues
2712	Employee Purchase
	\$ _____
	Pay Periods: 1 2 3

HEALTH	DENTAL
<input type="checkbox"/> Employee	<input type="checkbox"/> Employee
<input type="checkbox"/> 2-Party	<input type="checkbox"/> 2-Party
<input type="checkbox"/> Family	<input type="checkbox"/> Family
VISION	VOL LIFE
<input type="checkbox"/> Employee	<input type="checkbox"/> Employee
<input type="checkbox"/> 2-Party	<input type="checkbox"/> Spouse
<input type="checkbox"/> Family	<input type="checkbox"/> Child