# Vermont State Employees' Association
## State of Vermont Employee Request for Payroll Deduction

I hereby request the following action(s) for payroll deduction and authorize the Department of Finance & Management to withhold from my salary every paycheck, the amount I have indicated below or an amount appropriate for my continued eligibility in the deduction plan. This request is effective this date and shall remain in effect until such time as I become ineligible or notify you in writing 10 days in advance that I want to cancel my deduction.

| | |
|---|---|
| **Employee Name (Print)** | **Date** |
| **Employee Signature** | **5 digit -Employee #** |

**Instructions:** As a permanent status State employee, you are eligible for payroll deduction of membership dues for the Vermont State Employees' Association (VSEA). As a VSEA member, you may also elect to participate in various benefit programs offered by VSEA, for which an additional deduction will be made from your pay check. This form must be completed, in full, and sent to VSEA in order to initiate a payroll deduction from your wages for VSEA dues and/or Member Benefit Program participation.

DO NOT CONFUSE THESE VSEA BENEFIT PROGRAMS WITH THE MEDICAL, DENTAL, OR LIFE INSURANCE PLANS OFFERED BY THE STATE OF VERMONT WHICH ARE AVAILABLE TO ALL PERMANENT STATE EMPLOYEES.
Please note: Insurance benefit programs offered by the VSEA are the sole responsibility of the VSEA. Payroll deduction of premiums for these programs should not be construed as an endorsement by the State of Vermont for either the Member Benefit Program or the company offering that product. Contact VSEA for more information on these programs and applicable costs.

**Mail or deliver this form directly to VSEA, 155 State Street, Montpelier VT 05602**

### Section 1 VSEA Membership Dues

☐ Start payroll deduction for **VSEA Membership Dues** each pay period VSEA Dues Amount: _____

☐ Stop Payroll deduction for **VSEA Membership Dues** each pay period.
*I understand that payroll deduction for the VSEA Member Benefit Program is a privilege of VSEA membership and will terminate if I terminate VSEA membership.*

*If you are cancelling your membership, please tell us your reasons for cancelling so that we can better serve our members in the future:*

_____

_____

_____

### Section 2 VSEA Member Supplemental Delta Dental Benefit Program

| | | check box | *for official use only* |
|---|---|---|---|
| ☐ | Start payroll deduction for **dental benefit** each pay period | ☐ One Person $9.45 | _____ |
| ☐ | Increase payroll deduction for **dental benefit** each pay period | ☐ Two Persons $20.02 | _____ |
| ☐ | Decrease payroll deduction for **dental benefit** each pay period | ☐ Three or more person $38.81 | _____ |
| ☐ | Stop Payroll deduction for **dental benefit** each pay period. | ***You must check the plan that matches your state dental plan*** | |

**For Official Use only**

_____ _____

VSEA Authorized Representative Signature Date