Self Funded Voluntary State Disability Insurance Plan
AUTHORIZATION TO REDIRECT VOLUNTARY PLAN BENEFITS

Name of Staff Member: ____
(Last) (First) (Initial)

Employer:______________________________

Social Security Number:_________________________________ Claim Effective Date: _______________________

This authorization may be filed at the time an individual applies for Voluntary Plan benefits or at any time while receiving these benefits. If the Voluntary Plan benefit recipient has been declared legally incompetent, the spouse of the individual, in the absence of any other legally authorized representative, shall have the right to continue or cancel the authorization for the redirection of Voluntary Plan benefits.

Current Payroll Deductions For This Staff Member:

Staff Member Paid Benefit Program	Weekly Deduction Amount

I authorize the above deductions from my weekly voluntary disability plan benefits.

I understand that I can terminate or change this deduction at any time while receiving voluntary plan benefits from my employer. I understand that these deductions from my Voluntary Plan benefits will continue until I terminate them.

Staff Member Signature: ____ Date: _____________________________

Sign below only if you wish to terminate all voluntary plan deductions.

I wish all deductions from my Voluntary Plan Benefits to terminate as of ____

Staff Member's Signature: ____ Date: ____________________________