Commonwealth of Massachusetts

DISCONTINUATION OF AUTHORIZATION FOR PAYROLL

DEDUCTION FOR INSURANCE OR OTHER EMPLOYEE BENEFITS

Agency/Dept: _____

Bargaining Unit: _____

Full Name (**First, Last, MI**): _____ (**Please print**)

Employee ID: _____

Address: _____

_____

_____

Home Phone: (____)_____

Company: _____

Please discontinue my payroll deduction for $_____ as of this date: _____. Since the Commonwealth can not notify the Company of individual insurance decisions, I understand that it is my responsibility to contact my Company, named above, within 60 days, to: cancel my coverage, set up an alternative payment mechanism, or replace an existing policy with another.

Employee Signature: _____ **Date:** _____