Workplace Benefit Advocates Team Insurance Services (WBAT)
Payroll Deduction through AFSCME Local 685

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visit us at: Wbatins.com

Your monthly deduction of $ _____ includes: $ _____WN/SL/OTHER INSURANCE COVERAGE + 1% UNION DUES (WHEN APPLICABLE)+ $ 9.00 ADMINISTRATION FEE AND SHOULD COMMENCE WITHIN TWO MONTHS.

Deductions will appear on your pay stub as code 448/EU114 AFSCME Local 685. Application or acceptance of benefits offered does not constitute membership in AFSCME or any of its local unions. **Policy cancellation:** mail, email, or fax written request to insurer, Local 685, and to WBAT for assistance with canceling both policy and deductions. Cancellation notices must be received by the 15th of the month in order to take effect by the next pay period. Otherwise, cancellation will take effect the following month. Administration fees are non-refundable. **Claims:** A claim may be filed by contacting Customer Relations. Washington National (800) 541-2254; Assurant (800) 733-7879; TWA (650)348-2300. WBAT Ins enrollment company helps facilitate payroll deduction but is in no way responsible for premiums deducted. We reserve the right to cancel payroll deduction or transfer pay codes at our discretion without prior notice. **Donation**: Your enrollment helps us support local charities. The charities we support help feed the hungry, shelter the homeless, provide education scholarships, promote entrepreneurism, rehome abandoned pets, and more. To see charities we support, go to **wbatins.com**. **This enrollment form may be photocopied and mailed to the address above. If you have any questions regarding your program(s), please contact your benefit representative.**

PAYROLL DEDUCTION AUTHORIZATION

By my signature, I certify that I: 1. am actively at work at least 20 hours/wk at the time of this enrollment; 2. authorize premium deductions from my pay check as of today's date and the auditor of the county of Los Angeles to adjust from time to time the amount of this deduction as may be required to comply with adjustments under the existing contract with the insurer. This authorization shall remain in effect until cancelled by me by written notice; 3. understand that I am not covered until approved; 4. represent that all of the information on this application is complete, correct and true to the best of my knowledge.

By my signature below, I affirm that I understand that this form is for payroll deduction only.

X_____ **Date:** _____
EMPLOYEE SIGNATURE

_____ _____
Printed Name (First, M.I. & Last) & Name of Insured (if different) **Work Email Address**

_____ _____ _____
Employee # **Dept #** **Work Number**

_____ _____
DOB **Home Address, City & Zip Code**

_____ _____
Cel phone **Work Address, City & Zip Code**

_____
Personal Email

Agent Information: _____ _____
Agent Name **Agent phone**

Policy Type/Monthly Premium:

CURRENT: Cancer $_____ Heart $_____ Accident $_____ Life $_____ Other $_____

NEW total: Cancer $_____ Heart $_____ Accident $_____ Life $_____ Other $_____