

**CLEVELAND CLINIC
PAYROLL DEDUCTION FORM**

EMPLOYEE NAME: _____

SOCIAL SECURITY NUMBER: _____ EMPLOYEE NUMBER: _____

DEDUCTION TYPE:

HEALTH PLAN COPAYMENT

OPTICAL PURCHASES

CCAC FITNESS CENTER

OTHER (PLEASE BE SPECIFIC): _____

PAYROLL DEDUCTION

PER PAY PERIOD: _____

TERMS: I hereby authorize a payroll deduction in the amount indicated above to be applied to the charges listed. In the event I terminate my employment at Cleveland Clinic, the balance due will be deducted from my final check. Should the balance due exceed the final pay amount, I agree to establish a repayment arrangement. In addition to the amount(s) set forth above, I will be responsible for paying Bank of America a \$25.00 fee for any Security Badges lost or not returned upon membership cancellation or for any replacement Badge and such amount may be deducted from my paycheck and remitted to Bank of America. **I understand that my payroll deduction will be terminated effective as of the next calendar month after the month in which I terminate my membership.**

EMPLOYEE SIGNATURE: _____ DATE: _____

DEPARTMENT REPRESENTATIVE: _____ DATE: _____

DIVISION CHAIRPERSON: _____ DATE: _____
(IF NECESSARY)

COMPENSATION AND BENEFITS: _____ DATE: _____
(IF NECESSARY)