



PAYROLL DEDUCTION AUTHORITY

CSEA, Inc./Local 1000, AFSCME, AFL-CIO
143 Washington Ave., Box 7125, Capitol Station, Albany, NY 12224

**Must be Completed if
Applying for Coverage.**

TO THE FISCAL OR PAYROLL OFFICER OF MY EMPLOYER:

I am a member of CSEA and hereby authorize you to deduct from my salary each payroll period the necessary amounts for payment of (check applicable boxes, if any).

- TERM LIFE INSURANCE
- PERMANENT LIFE INSURANCE
- DISABILITY INCOME INSURANCE
- PERSONAL LINES INSURANCE
- CRITICAL ILLNESS INSURANCE

Signature: _____ **Date:** _____

(PLEASE PRINT)

- Mr.
- Mrs.
- Ms.
- Miss

First	Middle	Last

Name of CSEA Local

Agency # (if any)	Payroll Item #	Social Security #

This space for CSEA office use only