International Association of Benefits
Group Enrollment Payroll Deduction Authorization

_____

Last Name First Social Security #

_____

Address City State Zip Code

_____

Home Phone Work Phone Fax Phone

Employer_____

Employer Address_____

Employer City & State_____**Zip**_____

Employer Phone #_____

PAYROLL DEDUCT **I authorize my employer to deduct from my salary or wages $_____ per month for my IAB membership.**

Additional Terms and Conditions: **I understand that this agreement will remain in effect until IAB has received a written notice from me that it should cancel. To ensure prompt cancellation of my IAB membership, this notice must be submitted at least 15 days, but no fewer than 3 days, prior to my next scheduled payment date.**

Employee Signature (Required) _____**Date**_____

Alliance ID#_____