Wayland	Representative	JAF

City/Town ◯	School ◯

Employee Name:

Work Location:

Payroll Deduction Authorization & Memorandum of Understanding

Product	Insured *(EE, SP,CH, FAM)*	Annual Premium	Deduction Mode	Deduction Amount
Cancer Expense				
Disability Plan				
Disability Plan				
Permanent Life				
Permanent Life				
Permanent Life				
Accident Plan				
Critical Illness				

I understand that all coverage is subject to underwriting and that my appliction can be declined.

I understand that the proposed issue date is: _____

I authorize my employer to make the deductions, as listed above, from my earnings.

Signature of Employee Date

WAIVER

I have been offered the opportunity to participate in this voluntary supplemental insurance benefit plan and I have declined.

I understand that if I should later desire to apply, evidence of insurability may be required.

Signature of Employee Date

*** (EE = Employee, SP = Spouse, CH = Child, FAM = Family)**