

PAYROLL DEDUCTION AUTHORIZATION
FOR STA WELFARE TRUST

Social Security Number: _____

Last Name: _____ First: _____ M.I.: _____

District Name: Spackenkill Union Free School District

Organization: Spackenkill Teacher's Association Trust Fund

TO THE BOARD OF EDUCATION:

I hereby authorize you, according to arrangements agreed upon with the above organization, to deduct from my salary and transmit to said organization, my employee contribution for the dental welfare trust in the amount and manner agreed to by the Spackenkill Union Free School District and the Spackenkill Teacher's Association. I hereby waive all right and claim to said monies so deducted and transmitted in accordance with this authorization and relieve the board of Education and all its officers from any liability therefor. I revoke any and all instruments heretofore made by me and for such purposes. This authority shall remain in full force and effect for all purposes while I am employed in this school system, or until revoke by me in writing between September 1st and September 15th of any given year.

Member Signature: _____

Date: _____