SED-4 (R 07/22)

Louisiana Dental Plan, Inc

State of Louisiana Employee Payroll Deduction Authorization

Employee Name	Soc. Sec. No.	Employee No. (for agency use)

Agency No.	Department/Agency/Section Name

I hereby authorize my employer to deduct a total of $_____6_____, monthly rate, from my salary until further notice and remit same to **Louisiana Dental Plan.** A TOTAL Semi-Monthly Deduction in the amount of $ _____3_____ represents one half of the total monthly premium required for the coverage(s) detailed below.

The Office of State Uniform Payroll and the employing agency are **not** representatives or agents of the employee or the vendor. It is the responsibility of the **employee** to notify each vendor he/she has a payroll deduction with of address and/or name changes. It is solely the responsibility between **the employee and the vendor** to ensure that the amount of any payroll deduction is correct and is properly credited to the appropriate policy. Cancellation of a policy must be submitted by the employee in a written request to **both** the vendor **and** his/her agency's payroll office. An employee signed SED-4 stopping the deduction may be required before the deduction can be stopped in the LaGov HCM payroll system. Statewide vendor deductions that are not taken due to an employee being on LWOP, not being due any wages, or not being paid enough wages to take the deduction **are the employee's responsibility** to pay directly to the vendor. Payments made outside of the payroll system are not pre-taxed. By signing this form, both the employee **and** the vendor representative acknowledge that the statements in this section have been read, are understood and are agreed upon.

DEDUCTION DETAIL (Product Names & Codes, 125 Eligible, Premium Amts.) MENU ELECTIONS

PRODUCT NAME	PLAN PART CD	YES	NO	125 ELIG	MO PREM.	PAYROLL CODE	INELIGIBLE & NON-	ELIGIBLE PART Semi-Mo.
Dental	23		N	Y	$	**ND**	$	
Dental	23	P		Y	$	**PD**		$

	Total Mo. Prem.	$
PP Begin Date	Total Semi-Mo. **Ineligible**	$
	Total Semi-Mo. **Non-Part.**	$
Date Authorized	Total Semi-Mo. **Part.**	$

By: _____

Employee Signature

TOTAL SEMI-MONTHLY $

(THIS FORM SUPERSEDES AND REPLACES ALL OTHER AUTHORITY FOR DEDUCTIONS FOR THIS VENDOR)

Presentation an deduction authorization processed by:

Louisiana Dental Plan Representative | Phone | Date

Company Address

Original: HR Payroll | Yellow: Home Office | Pink: Customer