Wage/salary deduction

Name ______________________________

Employer ______________________________

Branch/department ______________________________

Employment address ______________________________

____

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Employee number (if applicable) ______________________________

I/We authorise you to deduct the following in relation to the Southern Cross Health Society employer's work scheme:

a. The contribution appropriate for myself and/or my dependants including any future alterations;

b. and if applicable, on termination of my employment, sufficient contributions to continue my membership through to the end of the billing period or month;

c. and if applicable, I acknowledge that this authority in respect of my contributions may only be cancelled at the end of the billing period or month.

Employee signature(s) ______________________________ ______________________________

Date signed ______ /______ /______

FOR OFFICE USE ONLY

Members covered	Self	Spouse	Dependants	Adult dependants
Plan required				
	Cost of plan	$:		
	Less subsidy (if applicable)	$:		
	Employee Contribution	$:		

Weekly ☐ **Fortnightly** ☐ **Monthly** ☐

Entry date ______ /______ /______

Area stamp code

Group code

Membership number for existing member ☐☐☐☐☐☐☐☐