

CITY OF OTTUMWA – 7/1/2023
GROUP HEALTH INSURANCE PAYROLL DEDUCTION
AUTHORIZATION

Employee Name _____
Employee Number _____
Effective Date _____

Medical	Single	Employee/Spouse	Employee/Child	Family
<i>Bi-weekly deduction</i>	\$44.55	\$90.99	\$83.70	\$136.08
Select one				
Dental	Single	Employee/Spouse	Employee/Child	Family
<i>Bi-weekly deduction</i>	\$0.00	\$11.64	\$10.05	\$30.15
Select one				
Vision	Single	Employee/Spouse	Employee/Child	Family
<i>Bi-weekly deduction</i>	\$6.68	\$12.91	\$14.02	\$18.25
Select one				

*If none are selected, no coverage will be provided for that category.

Any changes/inquiries to Life Insurance Coverage please contact Barb or Katy at 683-0600

I hereby authorize the City of Ottumwa Payroll Division to deduct the above payment(s) for group, health, dental and vision per pay period. These deductions will be made the first two pay periods of each month.

Signature **Date**

I elect not to participate in the City of Ottumwa's Group Health Insurance Plan. I understand the opportunity to enroll at any future time will be subject to such arrangements as may be made with the insurance carrier.

Signature **Date**