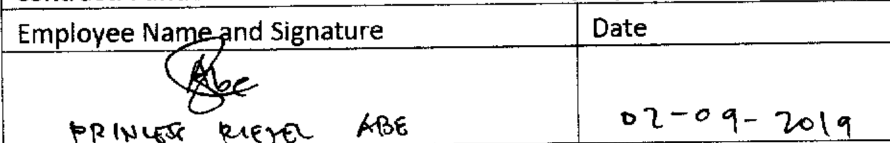
AUTHORIZATION TO DEDUCT INSURANCE PREMIUMS AND APPLICATION/ENROLLMENT OF DEPENDENTS

Employee Card Number: 1168 0110 4049 6563
Employee ID Number: 480

Employee/Principal Name (Fist, MI, Last):	PRINCESS RIEZEL ABE			
Dependents' Name (First, Middle, Last)	Gender	Birthdate	Civil Status	Relationship w/ the Principal (Parents, spouse, child, sibling)
1 ELIZABETH NAYNE ABE	F	08-16-1956	S	MOTHER
2				
3				
4				
5				
Quarterly Premium amount:	PHP: 2,805.07			
Monthly Payroll Deductions	PHP: 935.02			

Certification
Employee: I certify that the information I have given is true to my knowledge. I hereby authorize Iploy Inc (Employer) to withhold my dependent/s Health Insurance premiums through payroll deductions. I understand that if premiums will not be withheld due to insufficient income in a pay period to cover the required deduction, I remain responsible for making timely payments/s to Iploy Inc to maintain the coverage intact. I understand this authorization shall continue in effect until November 30, 2019. I understand that in case I will terminate my employment with Iploy Inc. (voluntary or involuntary), the company reserves the right to deduct from my last pay the remaining quarterly premium that my dependent/s were covered. I acknowledge that health insurance premiums and employee contributions are subject to change based on the health insurance contract. I understand that I am to immediately report any changes to Iploy Inc.



Employee Name and Signature	Date
PRINCESS RIEZEL ABE	02-09-2019