



AUTHORIZATION TO DEDUCT INSURANCE PREMIUMS AND APPLICATION/ENROLLMENT OF DEPENDENTS

Maxicare Card Number: 1168 0110 71491271				
Employee ID Number: 0789				
Employee/Principal Name (First, MI, Last):		Dioscoro L. Abangan		
Dependents' Name (Complete First, Middle, & Last Name)	Gender	Birthdate	Civil Status	Relationship w/ the Principal (Parents, spouse, child, sibling)
1 Renario C. Abangan	M	4-11-59	Widower	Father
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.	
Signature Over Printed Name	Date
Dioscoro L. Abangan	05-08-19