
WESTERN MICHIGAN UNIVERSITY

Sindecuse Health Center Pay Deduction Authorization

This agreement is made between _____, employee, and
(please print name)
Sindecuse Health Center, Western Michigan University. If I choose **NOT** to pay with cash, check, or credit card for charges incurred at Sindecuse Health Center, **I agree with the following:**

- Any dollar amount equal to or greater than \$5.00 owed by me to Sindecuse Health Center for the purpose of my healthcare will be deducted from my Western Michigan University pay.
- The **TOTAL** dollar amount owed to Sindecuse Health Center will be deducted from the pay period **DIRECTLY** following my visit to Sindecuse. Deductions will be made in accordance with applicable law.
- If I do not receive pay for the next pay period, I understand my charges will be placed on my University Account and I am responsible for payment.
- I may cancel this agreement with Sindecuse Health Center at any time by submitting a written request. However, I understand that any dollars owed Sindecuse at the time of cancellation will still be deducted from my next pay.

I also authorize any dollar amounts owed Sindecuse Health Center to be deducted from my pay for the following individuals who are considered my dependents:

NAME	SOCIAL SECURITY #	DATE OF BIRTH
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This agreement shall be legally binding while employed by Western Michigan University unless revoked in writing. I understand that I am not required to utilize this form of payment in order to receive services and treatment but I have freely elected to do so.

EMPLOYEE SIGNATURE _____

TODAY'S DATE _____

EMPLOYEE ID # _____ **SOCIAL SECURITY #** _____

DATE OF BIRTH _____

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For office use only
Date _____ Entered By _____