

CITY OF CABOT

REQUEST TO STOP PAYROLL DEDUCTION
(NOTE: This form is only valid for voluntary deductions.)

EMPLOYEE NAME: _____

EMPLOYEE SSN: _____-_____-_____

TYPE/NAME OF DEDUCTION: _____

CURRENT AMOUNT OF DEDUCTION: \$ _____

REASON FOR REQUEST: _____

EFFECTIVE DATE: _____

EMPLOYEE SIGNATURE

DATE

WITNESS SIGNATURE

FOR HUMAN RESOURCES USE ONLY

DATE PAYROLL DEDUCTION STOPPED: ___/___/_____

ENTERED BY: _____

LAST DAY OF COVERAGE: ___/___/_____

COVERAGE WITH COMPANY TERMINATED ON: ___/___/_____