# Employer Payroll Deduction Authorization

The person submitting this form wishes to have deductions made from their payroll distribution and sent to Managed Health Services (MHS) for Healthy Indiana Plan (HIP) health insurance premium payments. The employee should complete the "Employee Information" below, and a copy of the completed form should be faxed or mailed to MHS at the address on the bottom of this form. Payroll deductions associated with this employee's request should also be mailed to the address below. Please contact MHS Member Services at 1-877-647-4848 with questions.

**Employee Information**

Name: _____

HIP ID #: _____

Address: _____

Name of Employer: _____

Begin date (Must be the first of the month): _____

Amount to Be Withheld Each Pay Period: $ _____

**Please list how you are paid:**

☐ Weekly ☐ Every two weeks ☐ Every month

☐ Other (please list): _____

**Authorization**

I hereby authorize _____to make deductions from any compensation or monies due to me in the amount listed above. The monies deducted will be applied to contributions required to be made to MHS, Incorporated for participation in HIP. The deductions will be taken through the current calendar year, or until I no longer wish to participate or until I terminate my employment.

Employee Signature:_____Date:_____
By signing this form, I attest that I have read and understand the above authorization.

**Employer Information**

Payroll Address: _____

City _____ State_____ ZIP_____

Contact Name: _____

Contact Phone: _____

Employer agrees to this optional program to allow employee deductions and forwarding to MHS? ☐ Yes ☐ No

Please fax or mail this form to: MHS, Attn: Premium Payments, 550 N. Meridian Street, Suite 101, Indianapolis, Indiana 46204. FAX: 1-866-855-9947.

The employer and employee should retain a copy of this form. 211.PWR.FI.O.FO