WASHINGTON STATE LiLA Lifelong Learning Accounts

FORM D

For Internal Use Only
LiLA Participant #_____
Date Received _____
Date Approved _____

AUTHORIZATION FOR PAYROLL DEDUCTION

(Please return to employer)

☐ **New** ☐ **Change** ☐ **Inactive** **Effective Date:** _____

**Please note that only your payroll office can confirm the exact effective date.*

Please use this form to initiate or make changes to your LiLA payroll deduction.

1) Employee Information

Employee Name: _____ SSN#: _____

Mailing Address: _____ Home Phone Number: _____

City/State/Zip: _____ Work Phone Number: _____

Email Address: _____ Cell Phone Number: _____

Monthly contribution: _____

3) Employer Information

Employer Name _____

Payroll Contact: _____

Payroll Contact Phone Number: _____ Payroll Contact Email: _____

4) Employee Agreement

I agree to take the following steps:

- if I wish to make changes or stop deductions to submit this form to my employer to make changes
- notify Washington LiLA when a deduction will not be taken for one or more pay periods.

By signing this form, I understand that payroll deduction be established or modified as indicated above and agree to the preceding terms.

_____ _____

Employee Signature *Date*

Return to your employer and make a copy for your records.