

<b>Name:</b> _____	<b>Empl ID:</b> _____	<b>Monthly Stipend Amt:</b> _____
<b>Mailing Address:</b> _____	<b>City/State/Zip:</b> _____	
<b>Home Phone:</b> _____	<b>Work Phone:</b> _____	<b>Cell Phone:</b> _____
<b>Fellowship PI or Training Grant PI:</b> _____	<b>Start Date:</b> _____	<b>End Date:</b> _____

**Post-Doctoral Trainee/Fellows Only:**

I hereby request the following action:

**Monthly**

- |                          |        |   |                   |
|--------------------------|--------|---|-------------------|
| <input type="checkbox"/> | ADD    | New withholding authorization for medical insurance | Amount: _____     |
| <input type="checkbox"/> | ADD    | New withholding authorization for dental insurance  | Amount: _____     |
| <input type="checkbox"/> | ADD    | New withholding authorization for vision insurance  | Amount: _____     |
| <input type="checkbox"/> | ADD    | New withholding authorization for parking           | Amount: _____     |
| <input type="checkbox"/> | CHANGE | Change withholding amount for medical insurance     | New Amount: _____ |
| <input type="checkbox"/> | CHANGE | Change withholding amount for dental insurance      | New Amount: _____ |
| <input type="checkbox"/> | CHANGE | Change withholding amount for vision insurance      | New Amount: _____ |

**TERMINATE:**       Parking       Medical       Dental       Vision

I understand that this authority is to remain in full force for the duration of my training/fellowship at OUHSC and can only be terminated if: (A) my training/fellowship ends at OUHSC, at which time this agreement will expire; (B) The event of my death, at which time this agreement expires immediately, upon notification; or (C) I change or terminate my withholding. I am providing this information to facilitate my personal needs and all information shall be considered personal and held in confidence.

Trainee/Fellow Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please send complete Form to [gca@ouhsc.edu](mailto:gca@ouhsc.edu)**

For GCA Use Only:	Date: _____	Initials: _____
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