

USE

BAPTIST HEALTHCARE SYSTEMS/ OLDHAM COUNTY EMS KY BI-WEEKLY PAYROLL DEDUCTION AUTHORIZATION

l,(Please print name leg	, hereby authorize Baptist Healthcare ase print name legibly)							
Systems to deduct \$	from my bi-weekly paycheck until further							
notice. I further authorize	ze Baptist Healthca	re Systems to forw	ard said fu	nds to:				
	P. O. Bo	G HEROES, INC ox 991547 Y 40269-1547						
EMPLOYEE SIGNATURE		SSN or PAYROLL ID						
SUPPORTING HI		VIBERSHIP I (Baptist Healthcare S						
NAME								
RANK/TITLE								
MEMBERSHIP TYPE: MAILING ADDRESS			·	·				
CITY/STATE/ZIP								
EMAIL(NOTE: Keeping our me	mbers informed via email hel	ps us to keep our operating	expenses to a m	ninimum.)				
PHONE (Optional)								
AMOUNT AUTHORIZE PER BI-WEEKLY PAY		DATE:						
NOTE: Individual mem membership (two adults	•		• • •	and family				
FOR MMBR# MEMB OFFICE	ZIP+4 CARD	EMAIL PACKET	GROUPS	AGENCY				

TO BE COMPLETED FOR FAMILY MEMBERSHIP ONLY

Family membership includes all members of a household -- including a spouse/significant other and dependent children. SUPPORTING HEROES uses the same definition of 'dependent child' as the federal government for PSOB purposes: 18 or younger; 19-22 and a full-time student; or any age if incapable of self-support due to physical or mental disability.

	NAME as it should appear on membership card	BIRTHDATE optional for spouse / required for children	GENDER	FULL- TIME STUDENT if age 19 to 22	EMAIL
SPOUSE			M / F		Requested (but optional)
	If spouse is in Public Safety, rank/title and agency:				
DEPENDENT CHILD			M / F	Y / N	
DEPENDENT CHILD			M / F	Y / N	
DEPENDENT CHILD			M / F	Y / N	
DEPENDENT CHILD			M / F	Y / N	
DEPENDENT CHILD			M / F	Y / N	
DEPENDENT CHILD			M / F	Y / N	