



**CommWell Health Eagle Foundation
Colleague Payroll Deduction Form
CONTRIBUTION SET UP, CHANGE OR CANCEL (PAYROLL DEDUCTION)**

I, _____ (Insert Full Name of Donor) hereby pledge and authorize CommWell Health to deduct from my paycheck each pay period (as indicated below) as a charitable contribution from me to the CommWell Health Eagle Foundation. I hereby direct that the donation made by me herein shall only be used by the CommWell Health Eagle Foundation for CommWell Health as they continue to make quality Healthcare available to ALL People. I further understand that I may cancel my donation at any time by providing written notice to the Foundation department at least 10 days prior to the next effective payroll deduction.

I understand that CommWell Health Eagle Foundation is relying on this donation from me to support the CommWell Health Eagle Foundation that will allow ALL People Quality and Affordable Healthcare.

Amount of Bi-Weekly Deduction: ___ \$5| ___ \$10| ___ \$15| ___ \$20| ___ \$25| ___\$50| _____ Other \$ Per pay period

ACCOUNT INFORMATION

Participant's Name: _____

Last Name First Name MI

Name on Acknowledgment Donor Wall: _____

Home Address: _____, _____ City, _____, State, _____ Zip

Work Email: _____ Personal Email: _____

Department: _____ Location: _____

Phone: _____

SET UP, CHANGE, OR CANCEL ANNUAL GIVING PAYROLL DEDUCTION:

(Initial) * I authorize CommWell Health to deduct this amount from my payroll every two weeks and contribute it to the Eagle Foundation's annual Campaign indefinitely.

(Initial) * I authorize CommWell Health to change my payroll deduction amount to _____ until further notice.

(Initial) * I want to cancel my contribution until further notice.

Please allow 2-3 weeks to process the payroll deduction contribution form.

(Internal Use Only)

Payroll Deduction will begin the first pay period of _____ / _____
Month Date

AUTHORIZATION FOR BIWEEKLY PAYROLL DEDUCTION

Signature of Employee

Date:

Signature of Chief Financial Officer

Date: