



**CRL PAYROLL DEDUCTION AUTHORIZATION**

**TO CRL:** Please send the billing statement to my employer/company at the following address:

EMPLOYER/COMPANY NAME		APPLICANT'S NAME		
EMPLOYER'S STREET ADDRESS	CITY	COUNTY	STATE	ZIP CODE
EMPLOYER CONTACT PERSON			TELEPHONE (   )	

**TO MY ABOVE NAMED EMPLOYER AND CRL:**

**As a convenience to me, I request and authorize my employer to:**

- (1) deduct the amount of the insurance premium, administration charges and membership dues from my compensation by way of payroll deduction; and
- (2) receive the insurance billing statement and remit the amount due directly to CRL on my behalf.

**I further request and authorize CRL to:**

- (1) send the insurance billing statement directly to my employer/company written above; and
- (2) accept the premium, membership dues, and administration charges, if any, directly from my employer/company on my behalf.

**I understand and agree that:**

- (1) my employer/company is not acting as an agent of CRL by performing any of the above activities but is, instead, at all times acting as my agent;
- (2) I am responsible for the payment of the premium, membership dues and administration charges. Therefore, if my employer/company fails to submit the required amounts when due, all coverage will terminate as of the due date;
- (3) if my employer/company fails to submit the required amounts when due, CRL has no obligation to seek payment directly from me;
- (4) I agree to indemnify my employer/company and CRL and hold them harmless from any loss, claim, or liability that may arise out of, or be related to, this authorization, including, but not limited to, loss of coverage or benefits due to failure to remit payment in a timely manner; and
- (5) I understand and agree that my employer/company and CRL may rely on this authorization and act accordingly. I may revoke this authorization with 15 days advance written notice to my employer and to CRL.

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Date**

**Employer's Statement:**

I certify that I am not paying any part of the premium, fees or other cost of insurance for my employee(s), if any; nor am I reimbursing my employee(s) for any portion of the cost of this insurance.

I understand that this arrangement does not constitute an employer health plan within the meaning or purpose of Sections 106, 125, and 152 of the Internal Revenue Code, nor is it subject to the small employer laws of the state.

I understand as part of this agreement, I am responsible for providing copies of all correspondence to the above applicant.

\_\_\_\_\_  
**Signature of Authorized Employer Representative**

\_\_\_\_\_  
**Date**