Reset Values

The University of Oklahoma Health Sciences Center

Stipend Withholding Enrollment

Name:_____ **Empl ID:**_____ **Monthly Stipend Amt:**_____

Mailing Address:_____ **City/State/Zip:**_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

Fellowship PI or Training Grant PI:_____ **Start Date:**_____ **End Date:**_____

Post-Doctoral Trainee/Fellows Only:

I hereby request the following action: **Monthly**

☐ ADD	New withholding authorization for medical insurance	Amount:	_____
☐ ADD	New withholding authorization for dental insurance	Amount:	_____
☐ ADD	New withholding authorization for vision insurance	Amount:	_____
☐ ADD	New withholding authorization for parking	Amount:	_____
☐ CHANGE	Change withholding amount for medical insurance	New Amount:	_____
☐ CHANGE	Change withholding amount for dental insurance	New Amount:	_____
☐ 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

For GCA Use Only: Date:_____ Initials:_____