Confluent HEALTH

THE HONEY JAR

CONFLUENT HEALTH EMPLOYEE FOUNDATION PAYROLL DEDUCTION FORM

SECTION 1 - EMPLOYEE INFORMATION:

Name: _____ _____ _____
FIRST MIDDLE LAST

SSN: _____ Phone Number: _____

Email Address: _____

Clinic/Office Location: _____ Clinic/Office Phone: _____

SECTION 2 - CONTRIBUTION DETAILS:

New Contribution

- ☐ Amount of Donation per Check: _____
- ☐ Effective Pay Date: _____

Change of Contribution

- ☐ Amount of Donation per Check: _____
- ☐ Effective Pay Date: _____

Cancellation of Contribution

- ☐ Effective Date: _____

I authorize Confluent Health to implement the above payroll change.

_____ _____
Signature Date

Questions? Contact CHEF@GoConfluent.com or your local HR representative.
Return completed form to your local HR representative.