



**JTA PROTECT PLUS
FOR MEMBERS & STAFF OF THE
JAMAICA TEACHERS' ASSOCIATION (JTA)**

SALARY DEDUCTION AUTHORIZATION FORM
(Please fill form in block capital)

I _____
Christian Name Middle Name Surname

As a member of the Jamaica Teachers' Association (JTA), I elect JTA Protect Plus coverage for myself and on behalf of my eligible dependent(s). I authorize my Finance/Accounts Department to deduct the additional monthly sum from my salary representing the JTA Protect Plus premiums and forward same to Sagicor on my behalf. I also further authorize that within 30 days of notice, you shall act on any change to the initial salary deduction order made by me or by Sagicor and approved by JTA in writing. This authority shall remain in force until you are advised that it is superseded by another or cancelled by me.

NAME OF PAY SITE: _____

TRN: _____ - _____ - _____ Cell #: (____) _____ - _____

Email Address: _____

JTA Protect Plus: \$ _____ .00

Employee's No. _____

Signature _____

Date _____

JTA'S CERTIFICATION OF MEMBERSHIP: _____

JTA STAMP:

DATE: _____