DOROTHY BJORK ASSISTANCE FUND DEDUCTION APPLICATION

LAST NAME, FIRST NAME, MIDDLE INITIAL – PLEASE PRINT

CSEA ID NUMBER OR LAST 4 DIGITS OF SSN | CSEA CHAPTER NUMBER | EMPLOYER NAME AND DISTRICT

HOME ADDRESS | CITY | ZIP

(_____) WORK TELEPHONE (WITH EXTENSION) | (_____) HOME TELEPHONE | (_____) CELL PHONE

EMAIL ADDRESS | BIRTHDATE

I hereby authorize and direct my employer to deduct from my paycheck OR increase my Assistance Fund contribution monthly and transmit that amount to the CSEA Assistance Fund. I understand that my DOROTHY BJORK ASSISTANCE FUND contribution is in addition to my present CSEA dues deduction. The effective date will be the date of the next payroll following receipt of this application by the employer. This authorization shall remain in full force and effective until revoked in writing by me.

❑ START NEW PAYROLL DEDUCTION $ _____ per month.

❑ INCREASE CURRENT PAYROLL DEDUCTION: I want to increase my payroll deduction to $ _____ per month.

❑ ONE-TIME CONTRIBUTION $ _____

Send checks made payable to "CSEA Dorothy Bjork Assistance Fund," and application in an envelope and mail to CSEA Headquarters. (Address on reverse side of this card.)

DATE | MEMBER'S SIGNATURE

To turn in the *complete, dated and signed* application, hit the SUBMIT button to the right OR save and email the application to member_app@csea.com or mail it to CSEA Headquarters at:
CSEA Headquarters
Attn: Accounting Department
2045 Lundy Ave.
San Jose, CA 95131

Submit

California School Employees Association