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Horace Mann
Founded by Educators for Educators

The Horace Mann Companies
1 Horace Mann Plaza
Springfield, IL 62715-0001

Payroll deduction/reduction authorization

☐ New business ☐ Policy change

Employer/School district _____ Billing group# _____

Employee name _____ _____ _____
(please print) Last First Initial

Insured name _____ _____ _____
(if different than employee) Last First Initial

Street address _____

City _____ State _____ ZIP _____

Employee # or last 4 digits of Social Security # _____

Remarks _____

Billing mode (Select one) ☐ 12 ☐ 11 ☐ 10 ☐ 9 ☐ 20 ☐ 21 ☐ 24 ☐ 26 ☐ Other _____

Pay frequency (Select one) ☐ Monthly ☐ Semimonthly (Twice a month – Ex. 1 and 15) ☐ Biweekly (Every two weeks) ☐ Weekly

Date of first deduction
(Month/Day/Year) _____ Pay dates _____ and _____ (required for monthly and/or semimonthly)

After-tax deductions

Auto Policy # _____ Policy # _____ Policy # _____

Life Policy # _____ Policy # _____ Policy # _____

Life loan repayment $ _____ (per pay) for Life policy $ _____

Group Policy # _____ Amount $ _____

Annuity (Select one): ☐ IRA ☐ Roth IRA ☐ 403(b) Roth ☐ Non-Qualified Annuity

Contract #_____ Amount _____ (per pay)

Other after-tax deductions $ _____

Total after-tax deductions $ _____

Pre-tax deductions

Employee 403(b) Contract # _____ $ _____ (per pay) 457(b) Contract # _____ $ _____ (per pay)

Employer 403(b) Contract # _____ $ _____ (per pay) 457(b) Contract # _____ $ _____ (per pay)

Home office use only – Life only
Increase/decrease payroll deductions to pay Horace Mann Life Insurance Company by $ _____.

I hereby authorize you to deduct from my paycheck the amount billed by The Horace Mann Companies as due for insurance or retirement plans for which I subscribe. I understand the amount deducted from my paycheck may be subject to changes in accordance with the plan(s) for which I have subscribed and to which I may become entitled. I understand that the amount to be deducted from my paycheck may be subject to change without further authorization from me. These changes may result in an increase or decrease of my paycheck deductions without requiring further written authorization from me. I further understand that upon my revocation of the authorization in writing, or by the insurer discontinuing the deduction program, the balance of any amount owed becomes my responsibility.

☐ Signature on file Employee signature _____

Date _____ Agent # _____

Auto: Fax this form to 866-710-0814, Attn: School Payroll Dept.
Life: Fax with signed application to 877-208-4116; or 877-208-4558; or 877-711-7893
Annuity: One copy to employer and return original to P.O. Box 4657, Springfield, IL 62708-4657