

**REQUEST AND AUTHORIZATION FOR VOLUNTARY ALLOTMENT
OF COMPENSATION FOR PAYMENT OF EMPLOYEE ORGANIZATION DUES**

Name of Employee (Print or Type Last, First, Middle)

Employee Social Security Number

Home Address, City, State and Zip Code

Agency Name and Address of SSA office (If Level 2 Office, Show Parent Office in Parenthesis)

NAME OF EMPLOYEE ORGANIZATION

I hereby certify that the regular dues of this organization for the above named member are currently established at \$3.50 per (biweekly pay period)

Signature Authorized Official

Title of Authorized Official

Date:

SECTION B - AUTHORIZATION BY EMPLOYEE

I hereby authorize the above named agency to deduct from my pay each pay period, or the first full pay period of each month, the amount certified above as the regular dues of the ATLANTA REGION SOCIAL SECURITY MANAGEMENT ASSOCIATION and to remit such amounts to that employee organization in accordance with its arrangements with my employing agency. I further authorize any change in the amount to be deducted which is certified by the above named employee organization as a uniform change in its dues structure.

I understand that this authorization, if for a biweekly deduction, will become effective the pay period following its receipt in the payroll office of my employing agency; and that, if for a monthly deduction, it will become effective the first full pay period of the calendar month following its receipt in the payroll office of my employing agency. I further understand that revocation forms, Standard Form No. 1188, Revocation of Voluntary Authorization for Allotment of Compensation for Payment of Employee Organization Dues, are available from my employing agency and that I may revoke this authorization at any time by filing such a revocation form or other written revocation request with the payroll office of my employing agency. Such revocation will not be effective however until the first full pay period following March 1st or September 1st of any calendar year, whichever date first occurs after the revocation is received in the payroll office.

Signature of Employee

Date:

APPLICATION FOR MEMBERSHIP

(NOTE: Applications should be sent to your Area Vice President with dues or the dues withholding form.)

I hereby apply for membership in the Atlanta Region Social Security Management Association (ARMA). I understand this will make me a member of the National Council, Social Security Management Associations (NCSSMA).

I authorize the Association to act on my behalf in Association business.

I agree to support the Association through payment of dues and through personal participation.

Signature:

Date:

Name: (Print or type)

Position Title:

Office Address:

Work Email Address:

Home Email Address:

DO NOT WRITE BELOW THIS LINE - FOR USE BY THE ASSOCIATION

FOR THE AREA VP

Original application forwarded to Secretary on this date:

Copy of application, with dues or dues withholding form forwarded to Treasurer on this date:

Original application forwarded to Secretary on this date:

Area Vice President Signature:

Date:

Area Vice President Name:

FOR THE SECRETARY

Certified and Recorded on this date:

Secretary Signature:

Date:

Secretary Name: