

**TWELVE MONTH PAY AUTHORIZATION AND
AGREEMENT FOR NINE-MONTH EMPLOYEES**

Name _____ **SSN or EMPID** _____
Please Print Clearly

Address _____

I hereby authorize the University of Arkansas, Fayetteville to deduct twenty-five percent (25%) of my nine-month (appointed) net salary from my paychecks during the period August through May. I understand that the University will return these monies to me in three equal installments in the months of June, July and August and will be mailed to the address specified above. **No direct deposit of these monies will be available.** I further understand that I must renew this authorization every year and that once I have signed up for the program that I may not withdraw my authorization nor have early access to those monies deducted.

Please begin Fall of 20_____

Signature _____ **Date** _____