**This form is available electronically.**

**FSA-444**
(06-21-12)

**U.S. DEPARTMENT OF AGRICULTURE**
Farm Service Agency

# REQUEST FOR OR TERMINATION OF VOLUNTARY ALLOTMENT OF PAY FOR USDA FSA RECOGNIZED ASSOCIATIONS

**NOTE:** *The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a - as amended). The authority for requesting the information identified on this form is 5 USC § 5525 - Allotment and Assignment of Pay. The information will be used to process an employee request to begin or terminate a voluntary allotment of pay. The information collected on this form may be disclosed to other Federal, State, Local government agencies, Tribal agencies, and nongovernmental entities that have been authorized access to the information by statute or regulation and/or as described in applicable Routine Uses identified in the System of Records Notice for GOVT-1, General Personnel Records, USDA/FSA-6, County Personnel Records, and USDA/FSA-7, Employee Resources Master File. Providing the requested information is voluntary. However, failure to furnish the requested information will result in an inability to process an employee request to begin or terminate a voluntary allotment of pay.*

*The collection of information is completed by current Federal employees and is therefore excluded from the Paperwork Reduction Act Requirement as specified in the 5 CFR 1320.3, and OMB approval is not required for this collection of information.*

*The provisions of appropriate criminal and civil fraud, privacy, and other statutes may be applicable to the information provided.*

| 1. Name of Employee *(Last, First, Middle)* | 2. Last 4 Digits of SSN |
|---|---|
| 3. Home Address of Employee *(Including Zip Code)* | 4. Name of USDA Agency *(Including Division/Branch)* |
| | 5. State/County of Employment |

6. Association *(Check One)*:

☐ NASCOE ☐ NAFEC ☐ NASE ☐ NACS ☐ Other: _____

7. **Type of Allotment** *(Check one)* ***Note:*** *A separate FSA-444* ***must*** *be filled out for each type of allotment*:

☐ **ASSOCIATION DUES**

I hereby authorize the Farm Service Agency (FSA) all of the following:

- to deduct from my pay on a biweekly basis the amount certified as the regular dues of the Association or state affiliate beginning PP ___ of CY ____.
- to make ***any changes*** in the amount which is certified by the Association or the state affiliate as an uniform change in its dues structure.
- to remit the dues withheld to the Association in accordance with its arrangements with FSA.

☐ **SUPPLEMENTAL INSURANCE COVERAGE**

State: _____ Association: _____

I hereby authorize the Farm Service Agency (FSA) all of the following:

- to deduct from my pay on a biweekly basis the amount certified by me as the premium for insurance elected by me through the NASCOE authorized carrier beginning PP __ of CY ____.
- premiums withheld will be remitted to the NASCOE carrier in accordance with the agreement between NASCOE and FSA. I understand that if my pay is insufficient to withhold the premium due, I am responsible for paying such premiums directly to the NASCOE carrier if I want to continue my insurance coverage.

*I understand this authorization must be filed with the State FSA Office at least* ***3 days*** *before the end of the pay period in which the first deduction will be made. I further understand this authorization will be terminated at any time I give written notice or in case of my separation for any reason. In either case, such termination will be effective only to prohibit further withholdings.*

| 8. Signature of Employee Requesting Allotment | 9. Date *(MM-DD-YYYY)* |
|---|---|

10. **Termination of Allotment** *(Check One)*:

State: _____ Association: _____

I request payroll deduction for the following allotment be terminated on the first day of Pay Period _____ of CY _____.

☐ NASCOE Dues ☐ Supplemental Insurance Coverage ☐ NAFEC Dues
☐ NASE Dues ☐ NACS Dues ☐ Other: _____

| 11. Signature of Employee Terminating Allotment | 12. Date *(MM-DD-YYYY)* |
|---|---|

13. **State Office Action** ***(Check NFC tables to determine current PP dues, or supplemental amount)*****:**

| A. Date Received *(MM-DD-YYYY)* | B. Effective Date *(MM-DD-YYYY)* | C. Date Updated *(MM-DD-YYYY)* |
|---|---|---|
| D. Name of Employee Updating Request | E. Signature of Employee Updating Request | |



**1 - AGENCY COPY**

**This form is available electronically.**

**FSA-444**
(06-21-12)

**U.S. DEPARTMENT OF AGRICULTURE**
Farm Service Agency

# REQUEST FOR OR TERMINATION OF VOLUNTARY ALLOTMENT OF PAY FOR USDA FSA RECOGNIZED ASSOCIATIONS

**NOTE:** *The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a - as amended). The authority for requesting the information identified on this form is 5 USC § 5525 - Allotment and Assignment of Pay. The information will be used to process an employee request to begin or terminate a voluntary allotment of pay. The information collected on this form may be disclosed to other Federal, State, Local government agencies, Tribal agencies, and nongovernmental entities that have been authorized access to the information by statute or regulation and/or as described in applicable Routine Uses identified in the System of Records Notice for GOVT-1, General Personnel Records, USDA/FSA-6, County Personnel Records, and USDA/FSA-7, Employee Resources Master File. Providing the requested information is voluntary. However, failure to furnish the requested information will result in an inability to process an employee request to begin or terminate a voluntary allotment of pay.*

*The collection of information is completed by current Federal employees and is therefore excluded from the Paperwork Reduction Act Requirement as specified in the 5 CFR 1320.3, and OMB approval is not required for this collection of information.*

*The provisions of appropriate criminal and civil fraud, privacy, and other statutes may be applicable to the information provided.*

| 1. Name of Employee *(Last, First, Middle)* | 2. Last 4 Digits of SSN |
|---|---|
| 3. Home Address of Employee *(Including Zip Code)* | 4. Name of USDA Agency *(Including Division/Branch)* |
| | 5. State/County of Employment |

6. Association *(Check One)*:

☐ NASCOE ☐ NAFEC ☐ NASE ☐ NACS ☐ Other: _____

7. **Type of Allotment** *(Check one)* ***Note:*** *A separate FSA-444* ***must*** *be filled out for each type of allotment*:

☐ **ASSOCIATION DUES**

I hereby authorize the Farm Service Agency (FSA) all of the following:

- to deduct from my pay on a biweekly basis the amount certified as the regular dues of the Association or state affiliate beginning PP ___ of CY ____.
- to make ***any changes*** in the amount which is certified by the Association or the state affiliate as an uniform change in its dues structure.
- to remit the dues withheld to the Association in accordance with its arrangements with FSA.

☐ **SUPPLEMENTAL INSURANCE COVERAGE**

State: _____ Association: _____

I hereby authorize the Farm Service Agency (FSA) all of the following:

- to deduct from my pay on a biweekly basis the amount certified by me as the premium for insurance elected by me through the NASCOE authorized carrier beginning PP __ of CY ____.
- premiums withheld will be remitted to the NASCOE carrier in accordance with the agreement between NASCOE and FSA. I understand that if my pay is insufficient to withhold the premium due, I am responsible for paying such premiums directly to the NASCOE carrier if I want to continue my insurance coverage.

*I understand this authorization must be filed with the State FSA Office at least* ***3 days*** *before the end of the pay period in which the first deduction will be made. I further understand this authorization will be terminated at any time I give written notice or in case of my separation for any reason. In either case, such termination will be effective only to prohibit further withholdings.*

| 8. Signature of Employee Requesting Allotment | 9. Date *(MM-DD-YYYY)* |
|---|---|

10. **Termination of Allotment** *(Check One)*:

State: _____ Association: _____

I request payroll deduction for the following allotment be terminated on the first day of Pay Period _____ of CY _____.

☐ NASCOE Dues ☐ Supplemental Insurance Coverage ☐ NAFEC Dues
☐ NASE Dues ☐ NACS Dues ☐ Other: _____

| 11. Signature of Employee Terminating Allotment | 12. Date *(MM-DD-YYYY)* |
|---|---|

13. **State Office Action** ***(Check NFC tables to determine current PP dues, or supplemental amount)*****:**

| A. Date Received *(MM-DD-YYYY)* | B. Effective Date *(MM-DD-YYYY)* | C. Date Updated *(MM-DD-YYYY)* |
|---|---|---|
| D. Name of Employee Updating Request | E. Signature of Employee Updating Request | |



**2 - ASSOCIATION COPY**

**This form is available electronically.**

**FSA-444**
(06-21-12)

**U.S. DEPARTMENT OF AGRICULTURE**
Farm Service Agency

# REQUEST FOR OR TERMINATION OF VOLUNTARY ALLOTMENT OF PAY FOR USDA FSA RECOGNIZED ASSOCIATIONS

**NOTE:** *The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a - as amended). The authority for requesting the information identified on this form is 5 USC § 5525 - Allotment and Assignment of Pay. The information will be used to process an employee request to begin or terminate a voluntary allotment of pay. The information collected on this form may be disclosed to other Federal, State, Local government agencies, Tribal agencies, and nongovernmental entities that have been authorized access to the information by statute or regulation and/or as described in applicable Routine Uses identified in the System of Records Notice for GOVT-1, General Personnel Records, USDA/FSA-6, County Personnel Records, and USDA/FSA-7, Employee Resources Master File. Providing the requested information is voluntary. However, failure to furnish the requested information will result in an inability to process an employee request to begin or terminate a voluntary allotment of pay.*

*The collection of information is completed by current Federal employees and is therefore excluded from the Paperwork Reduction Act Requirement as specified in the 5 CFR 1320.3, and OMB approval is not required for this collection of information.*

*The provisions of appropriate criminal and civil fraud, privacy, and other statutes may be applicable to the information provided.*

| 1. Name of Employee *(Last, First, Middle)* | 2. Last 4 Digits of SSN |
|---|---|
| 3. Home Address of Employee *(Including Zip Code)* | 4. Name of USDA Agency *(Including Division/Branch)* |
| | 5. State/County of Employment |

6. Association *(Check One)*:

☐ NASCOE ☐ NAFEC ☐ NASE ☐ NACS ☐ Other: _____

7. **Type of Allotment** *(Check one)* ***Note:*** *A separate FSA-444* ***must*** *be filled out for each type of allotment*:

☐ **ASSOCIATION DUES**

I hereby authorize the Farm Service Agency (FSA) all of the following:

- to deduct from my pay on a biweekly basis the amount certified as the regular dues of the Association or state affiliate beginning PP ___ of CY ____.
- to make ***any changes*** in the amount which is certified by the Association or the state affiliate as an uniform change in its dues structure.
- to remit the dues withheld to the Association in accordance with its arrangements with FSA.

☐ **SUPPLEMENTAL INSURANCE COVERAGE**

State: _____ Association: _____

I hereby authorize the Farm Service Agency (FSA) all of the following:

- to deduct from my pay on a biweekly basis the amount certified by me as the premium for insurance elected by me through the NASCOE authorized carrier beginning PP __ of CY ____.
- premiums withheld will be remitted to the NASCOE carrier in accordance with the agreement between NASCOE and FSA. I understand that if my pay is insufficient to withhold the premium due, I am responsible for paying such premiums directly to the NASCOE carrier if I want to continue my insurance coverage.

*I understand this authorization must be filed with the State FSA Office at least* ***3 days*** *before the end of the pay period in which the first deduction will be made. I further understand this authorization will be terminated at any time I give written notice or in case of my separation for any reason. In either case, such termination will be effective only to prohibit further withholdings.*

| 8. Signature of Employee Requesting Allotment | 9. Date *(MM-DD-YYYY)* |
|---|---|

10. **Termination of Allotment** *(Check One)*:

State: _____ Association: _____

I request payroll deduction for the following allotment be terminated on the first day of Pay Period _____ of CY _____.

☐ NASCOE Dues ☐ Supplemental Insurance Coverage ☐ NAFEC Dues
☐ NASE Dues ☐ NACS Dues ☐ Other: _____

| 11. Signature of Employee Terminating Allotment | 12. Date *(MM-DD-YYYY)* |
|---|---|

13. **State Office Action** ***(Check NFC tables to determine current PP dues, or supplemental amount)*****:**

| A. Date Received *(MM-DD-YYYY)* | B. Effective Date *(MM-DD-YYYY)* | C. Date Updated *(MM-DD-YYYY)* |
|---|---|---|
| D. Name of Employee Updating Request | E. Signature of Employee Updating Request | |



**3 - EMPLOYEE COPY**