Member Information	
First Name	
Last Name	
Cell Phone	Work Phone
Personal Email	
State Information	
State information	
County	
State	
Work Email	

This information along with the FSA-444 below will need to be completed and email to info@nascoe.org to process your membership request.

Your membership will be counted from the day you sign the FSA-444 form and submit it to the email above.

Your NASCOE APP approval will be processed by next day and you will be added to the NASCOE email listing.

Once the agency enters furlough procedures these forms will be stored and submitted to state offices once the agency has been funded again and payroll deductions will begin for membership dues to be collected.

Any questions, please contact info@nascoe.org.

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.

However, failure to furnish the requested information will result in an inability to proce				
The collection of information is completed by current Federal employees and is there	fore 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	· · ·			
Name of Employee (Last, First, Middle)	2. Last 4 Digits of SSN			
Home Address of Employee (Including Zip Code)	4. Name of USDA Agency (Including Division/Branch)			
3. Home Address of Employee (<i>including Elp Gode)</i>	4. Name of GODA Agency (medianing 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 ou	it for each time of allotment			
	ты еасттуре от апотпети.			
ASSOCIATION DUES I hereby authorize the Farm Service Agency (FSA) all of the following	owing:			
 to deduct from my pay on a biweekly basis the amount certified 	ed as the regular dues of the Association or state affiliate beginning			
PP of CY .	A			
 to make <i>any changes</i> in the amount which is certified by the Association in accordance with the dues withheld to the Association in accordance with the dues withheld to the Association in accordance with the dues withheld to the Association in accordance with the dues withheld to the Association in accordance with the dues withheld to the Association in accordance with the dues withheld to the Association in accordance with the dues with the due due due due due due due due due du	Association or the state affiliate as an uniform change in its dues structure. ith 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 .	of the as the premium for insurance elected by the through the			
• premiums withheld will be remitted to the NASCOE carrier in	accordance with the agreement between NASCOE and FSA. I understand			
	m 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 a				
deduction will be made. I further understand this authorization will be a separation for any reason. In either case, such termination will be effec				
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 da	y 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 A. Date Received (MM-DD-YYYY) B. Effective Date (MM-DD-Y				
D. Ellective Date (MM-DD-Y	C. Date opulated (ININI-DD-1111)			
D. Name of Employee Updating Request E.	Signature of Employee Updating Request			

The U.S. Department of Agriculture (USDA) prohibits discrimination in all of its programs and activities on the basis of race, color, national origin, age, disability, and where applicable, sex, marital status, familial status, parental status, religion, sexual orientation, political beliefs, genetic information, reprisal, or because all or part of an individual's income is derived from any public assistance program. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write to USDA, Assistant Secretary for Civil Rights, 1000 (Independence Avenue, S.W., Stop 9410, Washington, DC 20250-9410, or call toll-free at (866) 632-9992 (English) or (800) 877-8339 (TDD) or (866) 377-8642 (English Federal-relay) or (800) 845-6136 (Spanish Federal-relay). USDA is an equal opportunity provider and employer.

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

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	Employee Resources Master File. Providing the requested information is voluntary. Occupant of the system of Records Notice for GOV1-1, General Republication is continuous.			
The collection of information is completed by current Federal employees and is the 5 CFR 1320.3, and OMB approval is not required for this collection of information.	erefore excluded from the Paperwork Reduction Act Requirement as specified in the			
The provisions of appropriate criminal and civil fraud, privacy, and other statutes n	nay be applicable to the information provided.			
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 ☐ NAC				
7. Type of Allotment (Check one) Note: A separate FSA-444 must be filled	out for each type of allotment.			
PPof CY	ified as the regular dues of the Association or state affiliate beginning e Association or the state affiliate as an uniform change in its dues structure.			
SUPPLEMENTAL INSURANCE COVERAGE				
State: Association:				
I hereby authorize the Farm Service Agency (FSA) all of the fo	ollowing:			
	ified by me as the premium for insurance elected by me through the			
NASCOE authorized carrier beginning PP of CY .				
	r in accordance with the agreement between NASCOE and FSA. I understand I am responsible for paying such premiums directly to the NASCOE carrier if			
I understand this authorization must be filed with the State FSA Office	e 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 b				
separation for any reason. In either case, such termination will be eff				
Signature of Employee Requesting Allotment	9. Date (MM-DD-YYYY)			
10. Termination of Allotment (Check One):				
State: Association:	: <u></u>			
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:			
	12. Date (MM-DD-YYYY)			
11. Signature of Employee Terminating Allotment	12. Date (MM-DD-1111)			
13. State Office Action (Check NFC tables to determine current PP dues, of				
A. Date Received (MM-DD-YYYY) B. Effective Date (MM-DD				
D. Name of Employee Updating Request	E. Signature of Employee Updating Request			

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The provisions of appropriate criminal and civil fraud, privacy, and other statutes may be				
Name of Employee (Last, First, Middle)	2. Last 4 Digits of SSN			
Home Address of Employee (Including Zip Code)	Name of USDA Agency (Including Division/Branch)			
o. Home radices of Employee (mondaing Exp code)	Hallo di Gosti (molading Divoloni Braholi)			
	5. State/County of Employment			
6. Association (Check One):				
	Othor			
NASCOE NAFEC NASE NACS	Other:			
7. Type of Allotment (Check one) Note: A separate FSA-444 must be filled out fo	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 a PP of CY . 	s the regular dues of the Association or state affiliate beginning			
	ociation or the state affiliate as an uniform change in its dues structure.			
to remit the dues withheld to the Association in accordance with				
SUPPLEMENTAL INSURANCE COVERAGE				
State: Association:				
I hereby authorize the Farm Service Agency (FSA) all of the followi	ng:			
 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				
	esponsible for paying such premiums directly to the NASCOE carrier if			
I want to continue my insurance coverage.	asponsible for paying such premiums directly to the 14 be of current			
I understand this authorization must be filed with the State FSA Office at le	east 3 days before the end of the pay period in which the first			
deduction will be made. I further understand this authorization will be terr				
separation for any reason. In either case, such termination will be effective				
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)			
11. Signature of Employee Terminating Allotment	12. Date (MM-DD-1111)			
13. State Office Action (Check NFC tables to determine current PP dues, or sup	pplemental amount):			
A. Date Received (MM-DD-YYYY) B. Effective Date (MM-DD-YYYY)				
D. Name of Employee Updating Request E. Sig	nature of Employee Updating Request			

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