

**The University of Alabama in Huntsville**

# Wireless Communication Device Supplement Request

☐ Enrollment      ☐ Cancellation

**Name** (type or print) \_\_\_\_\_ **Date:** \_\_\_\_\_  
Last, First, MI

**Employee ID #:**    A                                      **Department:** \_\_\_\_\_  
 \_\_\_\_\_

**Email:** \_\_\_\_\_ **UAH ORG/Index Code to Bill:** \_\_\_\_\_

**Campus Address:** \_\_\_\_\_ **Work Phone #:** \_\_\_\_\_  
Building / Room Number

I request approval to enroll in The University of Alabama in Huntsville (UAH) Wireless Communication Service Supplement Plan. I have read and understand the appropriate policy on wireless communication device supplements as well as the employee responsibilities listed below.

The University will supplement the actual cost, not to exceed \$95 per month for voice and data service, or \$45 per month for voice service only. The supplement is a taxable benefit, but not part of the base salary. Initial proof of payment for the device and services is required and must be attached to this form and submitted to Payroll.

**Employee Responsibilities:**

1. The employee receiving a supplement must provide to his/her department and Payroll the telephone number of the communication device within five (5) working days of the activation of the number.
2. The employee is personally liable for contract stipulations including payment of all expenses incurred (including long distance, roaming fees, and taxes). In the event that an employee leaves the position which qualified for the supplement, he/ she continues to be responsible for the contractual obligations of the communication device plan.
3. The employee receiving a supplement must notify his/her department head and the Director of Payroll within five (5) working days of the inactivation of the wireless communication service or in the event the device is lost or stolen.
4. The maximum supplement per employee per month is \$95 for voice and data or \$45 for voice only. The employee may not receive multiple supplements from multiple departments on campus.

**Please mark only one selected supplement type:**

Voice & Data Supplement:    ☐ Monthly Cost: \$ \_\_\_\_\_      Voice Supplement:    ☐ Monthly Cost: \$ \_\_\_\_\_  
 Cost of Device / Hardware: \$ \_\_\_\_\_

**Wireless Device Information:**

Phone Number: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_

**Requestor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Required)

**Supervisor:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(If Applicable)

**Department Head / Dean:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Required)

**Vice President:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Required)

**Send completed form to: Kerry Goens c/o Payroll, SKH 151**

NOTE: Forms **must** be received by Payroll no later than the 5th day of the month for the supplement to be paid for that month.

**This area to be completed by Payroll**

Date Received in Office: \_\_\_\_\_ Date Processed: \_\_\_\_\_ Processed By: \_\_\_\_\_

Print Form

Revised 10/11/2018