TOWN OF WALPOLE

ELECTION FORM

BEFORE-TAX HEALTH CARE

PREMIUM PAYMENT PLAN

EMPLOYEE INFORMATION:

Please print or type required information and return to the Personnel Office:

NAME:
First:_________________________ MI _________ Last: ______________________

DEPARTMENT: ____

SOCIAL SECURITY NUMBER: ___________________________________

I have read and understood the notice describing the Before-Tax Health Care Premium Plan. I understand that my share of the premiums for the Town's Health Care Plan will be deducted from my paycheck on a before-tax basis unless I elected to waive this automatic option.

Indicate whether or not you choose to participate in the Plan:

[ ] **Participate**

[ ] **Not Participate**

______________________________________ __________________
Your Signature Date

***NOTE:**

IF THIS FORM IS NOT RETURNED TO THE PERSONNEL OFFICE ALONG WITH YOUR HEALTH INSURANCE ENROLLMENT FORM THEN THE TOWN WILL ASSUME YOU WISH TO PARTICIPATE IN THE BEFORE-TAX HEALTH CARE PREMIUM PLAN.