TOWN OF BERKLEY
MASSACHUSETTS

OFFICE OF
TREASURER

TOWN OF BERKLEY

PRE-TAX PREMIUM PAYMENT PLAN

EMPLOYEE INFORMATION

Please print or type the information requested and return this form, **SIGNED,** to the Town of Berkley.

NAME: _____

STREET: _____

CITY OR TOWN: _____

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING THIS FORM

I hereby authorize the Town of Berkley to deduct any Medical, Dental, Disability, Cancer and Accident insurance from my paycheck prior to taxes under IRS Sec 125. **I must remain on the plan for one year.**

Signature: _____

Date: _____