Village of Bloomingdale
Medical and Dental Insurance Premium Contributions
Benefit Election Waiver Form

Print Employee Name: _____

Department: _____

Benefit Election:

_____ **I elect to have my medical and dental insurance premium contributions deducted from my pay on an after tax basis.**

Effective Date of Waiver: July 1, 20____ or _____

Salary Redirection Agreement:

I understand that I have the right to have the Village of Bloomingdale redirect my salary on an after tax basis as herein elected during the plan year and apply this amount toward the purchase of medical and dental insurance coverage. I understand that my share of the cost of this coverage may be adjusted from time to time to reflect the change in rates charged by the carriers. My election shall continue in effect during the plan year, and shall remain in effect from plan year to plan year, unless I give written notice to the Village during the annual open enrollment period of my election change. I acknowledge that my election is irrevocable during the plan year unless there is a change in my family status and I notify the Village within 30 days of the change. A change in family status includes marriage, divorce, death of a spouse or dependent, birth or adoption of a child, or a change in your or your spouse's employment status, or as otherwise permitted by the Internal Revenue Service and the Village's plan document.

Employee Signature: _____

Date Signed: _____

Authorized Village Representative: _____

Date Signed: _____