BENEFITS DIVISION PREMIUM REIMBURSEMENT AGREEMENT FORM

To: Benefits Division, Human Resources Department

I acknowledge that during any period of paid or unpaid leave in which I am absent due to Family Medical Leave (FMLA), Worker's Compensation Leave, and/or Leave of Absence (LOA), which also includes Suspension Leave and Military Leave, the City has the right to recover the cost of any premiums paid by the City on my behalf to maintain my or my dependent's benefits coverage.

Upon my return to work, I understand that the Employee Benefits Division will begin payroll deductions immediately for all premiums due unless another agreement has been made to pay premiums owed over several pay periods.

FMLA, Military & Workers' Compensation Leave: By acknowledging this agreement, benefit coverage for *my* Medical and Dental will remain intact throughout my Family Medical Leave, Military Leave, and/or Workers' Compensation Leave without a lapse in coverage. I understand that I must maintain my benefit premium payments on a bi-weekly basis for any *dependent* coverage or any optional benefit coverage(s) I have elected. If my benefit premium payments are not paid in a timely manner, the City reserves the right to cancel my dependent's coverage and any optional benefit coverage(s) in force. A timely manner is defined as not more than 30 days pass the due date. If, during this time any medical or dental claims are paid on my behalf for claims submitted, I understand the City may authorize the carrier and/or administrator to reverse payment for such paid claims. It will be my responsibility to reimburse the providers for the full cost of those claims.

LOA Leave: *During a Leave of Absence, the City terminates payment of its portion of medical and dental coverage for you and your dependent(s].* By acknowledging this agreement:

I understand that I must maintain my premium payments on a bi-weekly basis for any single or dependent coverage I have elected, including optional benefits. If my premium payments are not paid on a timely basis, the City reserves the right to cancel any coverage I have elected including dependent and optional benefit coverage. The City's obligation to maintain my health care coverage ends if my premium payments are more than 30 days pass the due date. If, during this time any medical or dental claims are paid on my behalf for claims submitted, I understand the City may authorize the carrier and/or administrator to reverse payment for such paid claims. It will be my responsibility to reimburse the providers for the full cost of those claims.

Our Mailing Address is provided below:

City of Round Rock
HRD - Benefits Division
231 E. Main Street, Suite 100
Round Rock, TX 78664

I certify by my signature that I have read and agree to the following agreement and understand, if I do not return to work, the Benefits Division will deduct premiums owed from my final City of Round Rock paycheck.

Name _____ **Employee Number**_____
(Print)

Address _____ **Dept:** _____

City _____ **State** _____ **Zip** _____

Signature _____ **Date** _____