UNPAID FAMILY AND MEDICAL LEAVE OR MILITARY LEAVE INSURANCE COVERAGE STATEMENT

Employee Name: _____ **Department:** _____

Employee ID #: _____ **Department Head Name:** _____

I understand that if my leave is approved, I am responsible for paying my portion of the premium for any benefits coverage. If payment is not received within 30 days from the date of the invoice, the County will automatically discontinue the affected coverage immediately.

Furthermore, I understand that I will be required to reimburse the County for premiums it paid on my and my dependents' behalf to maintain benefits coverage during any period of unpaid Family and Medical Leave Act (FMLA) leave **if** I fail to return to work after my FMLA entitlement or medical leave has expired, with the following exceptions:

1. The continuation, recurrence, or onset of a serious health condition that would entitle me to FMLA leave.
2. The continuation, recurrence, or onset of a covered service member's serious injury or illness that would entitle me to FMLA leave.
3. Other circumstances beyond my control.

I understand that the County will take any necessary steps to recover such premiums.

Select One:

☐ I wish to **discontinue** benefits coverage while on unpaid FMLA or military leave. Dropping health insurance is not retroactive; it is effective the following period after Payroll receives this notice. Dependents cannot be covered if the employee has elected to discontinue their own coverage. I understand that I must contact my department and Human Resources & Risk Management immediately upon my return to work so that benefits can be reinstated. My previous coverage will be reinstated on the next insurance begin date set out by the Auditor's office following notice of return to work.

OR

☐ I wish to **continue** benefits coverage while on FMLA/military leave. I understand that I will be billed for my portion of the premiums (if applicable) and that I am responsible for paying the premiums within 30 days from the date of the invoice. I further acknowledge that if I fail to pay my portion of premiums within 30 days, Harris County will immediately discontinue my health coverage including all dependent and optional coverages.

A copy of this form must be scanned and emailed to the Office of Human Resources & Risk Management at Benefits@harriscountytx.gov immediately upon completion.

_____ _____
Employee Signature Date

_____ _____
Department Head Signature Date