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AGREEMENT TO PAY AND/OR REIMBURSE EMPLOYER FOR INSURANCE PREMIUM

FMLA Leave

Employee Name _____ **Company** _____

I understand that the Family and Medical Leave Act (FMLA) allows me to continue as a participant in the Pay Plus Benefits Group Insurance Health Care Plan up to 12 work-weeks in a 12 month period in which I qualify for and take FMLA leave. My participation in the plan is on the same terms and conditions that exist at the time I begin FMLA leave.

Therefore, I agree that, and authorize my employer and Pay Plus Benefits to:

☐ Continue to deduct my share of the premium for insurance from each regularly issued paycheck that applies (paid leave, and/or sick leave) that I receive while on FMLA leave. _____ (Employee initials)

If you will not receive paychecks for the entire period of your FMLA leave (if you do not have enough paid leave or sick leave available to cover your entire leave), please complete the sections below that apply to you:

Premium Only Plan: Choose only one

☐ I have made arrangements with my employer and my employer has agreed to pay for my share of the premium(s) in my absence. Upon my return to work, I agree that I have elected a catch-up contribution (pre-tax only) and my employer is entitled to recover from me as an additional payroll deduction for each pay period the premium that was paid on my behalf until my employer is fully reimbursed.

☐ My employer has not agreed to pay for my share of the premium(s) in my absence. I understand that I may pre-pay my share of the premium(s) in the amount for the expected duration of the leave on a pre-tax salary reduction basis out of my pre-leave compensation. If there is a balance of unpaid premiums upon my return to work, I agree my employer is entitled to recover from me as an additional payroll deduction (pre-tax only) for each pay period the premium was paid on my behalf until my employer is fully reimbursed.

Medical Reimbursement Plan: Choose only one

☐ Reinstate Benefit at Same Coverage Level. Upon my return to work (returning from FMLA leave), I agree to increase my salary reduction contributions to make up for the contributions that I will/did not make during the leave. This will preserve my annual election at the total level I elected for the year. After I return, the Plan Administrator may increase my pro-rated amount of salary reduction for the remainder of the Plan Year or may require an additional payroll deduction to be made so that the annual election will be met within the Plan Year.

☐ Reduced Benefit. I choose to reduce my annual election for the period of FMLA leave during which I will/did not make salary reduction contributions. I understand that I must complete the Flexible Benefits Change in Election form within 30 days of my return from leave in order to restore my benefit.

Dependent Care Assistance Plan: Choose only one

☐ Reinstate Benefit at Same Coverage Level. Upon my return to work (returning from FMLA leave), I agree to increase my salary reduction contributions to make up for the contributions that I will/did not make during the leave. This will preserve my annual election at the total level I elected for the year. After I return, the Plan Administrator may increase my pro-rated amount of salary reduction for the remainder of the Plan Year or may require an additional payroll deduction to be made so that the annual election will be met within the Plan Year.

☐ Reduced Benefit. I choose to reduce my annual election for the period of FMLA leave during which I will/did not make salary reduction contributions. I understand that I must complete the Flexible Benefits Change in Election form within 30 days of my return from leave in order to restore my benefit.

Employee Signature _____ **Date Signed** _____