City of Marlborough
Human Resources Department

REQUEST FOR FAMILY AND MEDICAL LEAVE OF ABSENCE INSURANCE PREMIUM RECOVERY AUTHORIZATION FORM

To: City of Marlborough Comptroller

I certify by my signature that I have read and understand the following policy:

I acknowledge the City's legal right to recover the cost of any premium paid by it to maintain my coverage in group health benefits and/or group dental benefits during any period of unpaid leave under the following conditions:

1. I fail to return from the leave at the expiration of the leave in which I am entitled; and
2. The reason I fail to return to work is not one of the following:
    A. The continuation, recurrence or onset of a serious health condition that entitles me to care for a child, parent or spouse with a serious health condition; or
    B. Other conditions beyond my control prevent me from returning.

Employee's Signature: _____ **Date:** _____

Name (Printed):

Department: _____

INSURANCE PREMIUM REIMBURSEMENT AGREEMENT

I certify by my signature that I have read and agree to the following:

If I fail to return from leave, for any reason other than 2Aor 2B above, I agree to coordinate with the City to develop a mutually acceptable schedule to reimburse the City for the cost of any premium paid by it to maintain my coverage in group health benefits and/or group dental benefits during any period of unpaid leave taken by me.

Employee's Signature: _____ **Date:** _____

Name (Printed):