



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 2A or 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):

The City of Marlborough is an Equal Opportunity Employer. The City of Marlborough does not discriminate in hiring or employment on the basis of race, color, religion, sex, sexual orientation, gender identity and expression, age, genetic information, national origin, ancestry, disability, veteran status or membership in the armed services, marital status or any other protected category under federal or state law.