

CITY OF BROCKTON
Family and Medical Leave Act (FMLA)
Insurance Disclosure Agreement

To be completed by employee:

Suffix (Sr., Jr. etc)	Employee Name (Last, First, Middle Initial)	Department	Department Head
Position/ Title:		Last 4 Digits of SS#:	Employee ID #:
Mailing Address:			
Number/Street	City	State	Zip Code
Work Phone: () -	Home Phone: () -	Cell Phone: () -	

As a City of Brockton employee, I have requested Leave under the provisions of the Family Medical Leave Act, hereafter called FMLA. Under the FMLA, I may be granted a leave up to an aggregate of up to twelve (12) weeks over the next twelve (12) months per calendar year. If approved and during the leave period, my leave status becomes or is unpaid, payment(s) for my insurance coverage (medical insurance, optional life insurance and other voluntary insurance offerings) will become due. I understand that I am obligated to continue payment(s) during the leave period.

Please select one of the following options:

Paid Leave of Absence:

I agree to continue my health and/or life insurance deductions from my paid leave time for the entire leave period.

Unpaid Leave of Absence:

I agree, to contact Human Resources to establish a payment agreement until all monies have been repaid for my insurance coverage (medical insurance, optional life insurance and other voluntary insurance offerings). I understand that payments made will be applied to the balance owed and I am still responsible for payment of my insurance premium(s).

I do not participate in any type of insurance coverage or programs offered by the City of Brockton.

I hereby expressly agree that, in the event my employment terminates, either voluntarily or involuntarily, prior to the full repayment of any outstanding premiums (medical insurance, optional life insurance and/or other voluntary insurance offerings) owed to the City, the City may withhold the remaining amount owed from my final pay. I represent that this authorization is executed voluntarily and has not been made as a condition of my continued employment.

By signing below, I acknowledge that I understand and agree to the terms and conditions set forth above.

<i>Employee Signature</i>	<i>Date</i>
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Department of Human Resources

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www.cityofbrockton.com/hr