CITY OF FITCHBURG

Family and Medical Leave Act (FMLA) Insurance Disclosure Agreement

To be completed by employee

Employee Name (Last, First)	**Department**	**Supervisor**	
Position		**Employee ID**	
Mailing Address:			
Number/Street	**City**	**State**	**Zip Code**
Work Phone: ( )	**Home Phone:** ( )	**Cell Phone:** ( )	

As a City of Fitchburg employee, I have requested and been granted Leave under the provisions of the Family Medical Leave Act, hereafter called FMLA. Under the FMLA, I have been granted a leave up to an aggregate of up to twelve (12) weeks over the next twelve (12) months. During this time period, co-payment (s) for my insurance coverage (medical insurance and optional life insurance) will become due. I understand that I am obligated to contribute my co-payment (s) during the leave period.

The City of Fitchburg agrees to the following optional payment programs for employees who request an FMLA leave.

Please select one of the following options:

☐ I agree to have my co-payment (s) deducted from my paid leave time for the entire leave period.

☐ I agree, that upon my return to work, to have twice the monthly deduction withheld from my bi-weekly payroll until all monies have been repaid.

☐ I agree to remit payment for all insurance co-payments to the City of Fitchburg on or by the 1st day of each month. I understand that payments made on or by the 1st of each month will be applied to said month's premium.

I fully understand that if I choose not to return to work after the end of the leave, that my employment with the City of Fitchburg will be considered to have been voluntarily terminated and that the full premium payment (s) for my insurances during the leave period become due to the City of Fitchburg.

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

Employee Signature	***Date***