Howard County Public School System Benefits Billing Form

Employee name:_____ Employee ID_____

Benefits Billing Information - *Employees must elect one of the following options*

- ❑ I wish to continue my benefits beyond my approved FMLA or upon approval of a general leave of absence. The premium is determined by paid/unpaid status. If I reach unpaid status while on general leave, I will be responsible for 100% of the premium cost.
- ❑ I **do not** wish to continue my benefits beyond my approved FMLA or upon approval of a leave of absence. My benefits will terminate the last day of the month my FMLA ends.

I have read the above and understand the following:

- I am responsible for any missed premiums while on an unpaid leave of absence.
- I cannot cancel my health, dental, and vision benefit elections while on FMLA leave, unless there is a qualifying event.
- I need to re-enroll in benefits within 30 days of my return from a general leave of absence.
- I am eligible to convert my life and LTD policies to individual policies within 30 days of loss of coverage, while on an unpaid approved leave of absence beyond the FMLA leave period, and that the rates will be different.
- I have the option to cancel my benefits while on an unpaid general leave of absence.
- I understand that HCPSS will maintain my group term life insurance policy, while on paid/unpaid approved FMLA leave.
- I understand upon return to work, additional Health flex deductions will be taken to cover for any missed deductions while on unpaid FMLA leave.

By signing, I have read and understand the information contained in this document as it applies to my benefits while I am on an approved leave of absence from the Howard County Public School System.

Employee signature_____ Date____/_____/_____

HR Use only

FMLA leave: ❑ Yes ❑ No FMLA starts on__/__/_____ FMLA ends on__/__/_____

General leave: ❑ Yes ❑ No General leave starts on__/__/_____ General leave ends on__/__/_____