BENEFIT CONTINUANCE

As evident by my signature below, I _____ agree to abide by the following terms and conditions in order to continue my benefit coverage during my leave of absence as outlined below.

I □ DO □ DO NOT/NA want to continue **Health insurance** coverage at a monthly cost of _____
I □ DO □ DO NOT/NA want to continue **Dental insurance** coverage at a monthly cost of _____
I □ DO □ DO NOT/NA want to continue **Vision insurance** coverage at a monthly cost of _____
I □ DO □ DO NOT/NA want to continue **Voluntary life insurance** coverage at a monthly cost of _____
I □ DO □ DO NOT/NA want to continue **Long-term Disability** at a monthly cost of _____
I □ DO □ DO NOT/NA want to continue **Accident** at a monthly cost of _____
I □ DO □ DO NOT/NA want to continue **Critical Illness** at a monthly cost of _____
I □ DO □ DO NOT/NA want to continue **Flexible Spending Account** at a monthly cost of _____
I □ DO □ DO NOT/NA want to continue **Fremont YMCA membership** at a monthly cost of _____

**Please note that any coverages NOT continued may be subject to waiting periods and/or evidence of insurability upon re-election.*

I agree to pay for my share of the cost of the premiums. As a result, my total premium will be $_____ per month. Your first and last payment will be adjusted per payroll schedule to ensure your payments are up to date. You will need to contact the Home Office or the Human Resource Department for these amounts. Subsequent payments are due by the 10th of the month for the covered month and are to be made in full. Payment should be made to:

Campus Name: _____

Full Mailing Address: _____

For approved leaves due to pandemic infection control regulations, FMLA, Worker's Compensation, or an approved disability claim, complete the following: **I want to reserve a balance of _____ PTO hours (can choose up to 40 hours). If blank, all hours will be used.**

If approved, PTO can be spread over the duration of leave to cover semi-monthly benefit deduction costs. I agree to allow HR to allocate PTO in the aforementioned manner. _____ (team member's initial)

I understand that the combination of my PTO and any other paid benefits (i.e., disability, Worker's Compensation) cannot exceed 99% of regular weekly earnings, and my timecard will be adjusted accordingly by the Human Resource Department.

I understand that this agreement will continue until:

(a) I inform the company of my intent NOT to return to work at the end of the leave period.
(b) I fail to return to work when the leave entitlement is exhausted or not approved.
(c) My premium payment is more than thirty (30) days late and the company has given me written notice at least fifteen (15) days in advance advising that coverage will cease if payment is not received.
(d) I inform the company of my desire NOT to continue the health insurance coverage.
(e) A period of twelve (12) weeks from the first of the month following the beginning of your leave has passed. After this time, I may be given the option to continue the benefit under the COBRA guidelines. Otherwise, the coverage may be terminated at the conclusion of these twelve (12) weeks.

I understand that if I fail to return from a leave, I may have to repay any of the shares of insurance premiums paid by the company during the leave. This repayment must be received by the campus within thirty (30) days of written notification by the company.

I understand that I may continue these benefits during my leave on the same terms as I had prior to the leave, but that the company's obligation to continue to pay the employer's portion of the premium ends when the sooner of the following events occurs:

- When I inform the company of my intent NOT to return to work. If I fail to return from a leave, I may be required to repay the company's share of insurance premiums paid by the company during the leave period.
- A twelve (12) week period from the first of the month following the start of the leave has passed, and/or
- My premium payment is more than thirty (30) days late and the company has given me written notice at least fifteen (15) days in advance advising that coverage will cease if payment is not received.
- I inform the employer in writing of my desire to no longer utilize the benefit.

I further understand that after this time, I may choose to continue my benefits under the COBRA guidelines.

_____ _____
Signature of Team Member Date

_____ _____
Signature of Campus Representative Date

FORM COMPLETION INSTRUCTIONS: *Access ADP Benefits > Enrollments for semi-monthly cost. Multiply x 2 for monthly cost to insert above. Complete all highlighted areas.*

(Rev. 05/01/2023)