County Auditor's Form 459
Harris County, Texas (REV. 04/09)

FAMILY AND MEDICAL LEAVE
INSURANCE COVERAGE STATEMENT FOR CONTINUOUS UNPAID FMLA

Employee Name: _____ **Department:** _____

Department Head Name: _____

I understand that if my leave is approved I am responsible for paying my portion of the premium for any benefits coverage. If payment is not received within 30 days from the date of the invoice, the County will automatically discontinue the affected coverage immediately.

Furthermore, I understand that I will be required to reimburse the County for premiums it paid on my and my dependents' behalf to maintain benefits coverage during any period of unpaid Family and Medical Leave Act (FMLA) leave **if** I fail to return to work after my FMLA entitlement has expired, with the following exceptions:

1. The continuation, recurrence, or onset of a serious health condition that would entitle me to FMLA leave.

2. The continuation, recurrence, or onset of a covered servicemember's serious injury or illness that would entitle me to FMLA leave.

3. Other circumstances beyond my control.

I understand that the County will take any necessary steps to recover such premiums.

Select One:

☐ I wish to **discontinue** benefits coverage while on FMLA. Dropping health insurance is not retroactive; it is effective the following period after Payroll receives this notice. I understand that I must contact Human Resources & Risk Management immediately upon my return to work so that benefits can be reinstated. Coverage will be reinstated on the 1st or 16th of the month following notice. Employees who are covering dependents must complete a County Auditor's Form 774E, *Employee Health & Related Benefits Change Form*, to drop their coverage. Dependents cannot be covered if the employee has elected to discontinue their own coverage.

OR

☐ I wish to **continue** benefits coverage while on FMLA. I understand that I will be billed for my portion of the premiums (if applicable) and that I am responsible for paying the premiums within 30 days from the date of the invoice.

A copy of this form must be sent to the Office of Human Resources & Risk Management immediately upon completion.

_____ _____
Employee Signature Date

_____ _____
Department Head Signature Date