City of Chicago
Family and Medical Leave
Authorization for Recovery of Cost Coverage

To: The Benefits Manager

I certify by my signature that I have read and understand the following policy:

I acknowledge the City Of Chicago's right to recover cost of coverage paid by it to maintain my coverage in group health benefits during any period of unpaid leave under the following conditions:

I fail to return from leave at the expiration of the leave to which I am entitled, and

The reason I fail to return to work is **not** one of the following:

The condition, recurrence, or onset of a serious health condition that entitles me to leave to care for a child, parent or spouse with a serious health condition, or if I am unable to perform the functions of my position due to my own serious health condition, or

Other conditions beyond my control prevent me from returning

Date __________________________ Name (Print) __________________________________

Employee Number _______________ Name (Sign) __________________________________

HEALTH CARE COST REIMBURSEMENT AGREEMENT

I certify by my signature that I have read and agree to do the following:

If I fail to return from leave, for any reason other than 2-A or 2-B above, I agree to coordinate with the City of Chicago Risk/Benefits Division to develop a mutually acceptable schedule to reimburse the City of Chicago for any costs of coverage paid by it to maintain my coverage in group health benefits during any period of unpaid leave taken by me.

Date ________________________ Name (Print) _____________________________________

Employee Number ______________ Name (Sign) ______________________________________

(Note: This form is to be completed and returned with the application for Family and Medical Leave)

Original to Benefits Office
1 copy to employee; 1 copy in personnel file