

<b>DOVER SCHOOL DISTRICT</b>	<b>POLICY CODE: GCCBC-E3</b>
<b>DATE OF ADOPTION: OCTOBER 10, 2005</b>	<b>PAGE 1 OF 1</b>

DOVER SCHOOL DEPARTMENT  
FAMILY AND MEDICAL LEAVE ACT  
MEDICAL INSURANCE ELECTION

[Sign 1 OR 2 below.]

1. While I am on unpaid Family and Medical Leave, I wish to continue my health insurance. I agree to pay my share of the premium to the District on each regular payday (\$\_\_\_\_\_ per pay period).

- a. I understand that if I fail to pay my share of the health insurance premium when due, the District may (1) cancel my health insurance for the remainder of the leave or (2) pay my share of the premium and collect such amounts from me. If the District pays my share of the premiums, I hereby authorize the District to deduct such amounts from my paycheck when I return to work.
- b. I also understand that if I fail to return to work at the conclusion of the leave (or return to work but fail to say thirty (30) calendar days) unless caused by my serious health condition or that of my child, spouse, or parent, or by other circumstances beyond my control, the District may collect from me all premiums it paid for my health insurance during the period of the leave.

**WARNING: READ BEFORE SIGNING. THIS DOCUMENT CONTAINS AN AUTHORIZATION TO MAKE DEDUCTIONS FROM YOUR PAYCHECK FOR HEALTH INSURANCE PREMIUMS.**

\_\_\_\_\_  
Employee's Signature      Date      Witness

\_\_\_\_\_  
Employee's Name (print)

2. While I am on unpaid Family and Medical Leave, I do NOT wish to continue my health insurance.

\_\_\_\_\_  
Employee's Signature      Date      Witness

\_\_\_\_\_  
Employee's Name (print)