Oregon Coast Community College
400 SE College Way
Newport, OR 97366

Continuation of Benefits while on FMLA Form

Date

Name (Last, first, middle initial) | E Number

Street address, City, ST, ZIP Code

Primary phone number | Other phone number | Email address

Current Coverage:	**Continue?**	**YES / NO**			
☐ Medical/Health	$	☐ Vision	$	☐ Dental	$
☐ Life & AD&D	$	☐ Employee opt Life	$	☐ SEC 125 Deduction	$

Premiums:

Employer paid	Employee Paid
$	$

1. I understand that my Agency will continue to pay for the College's contribution of my medical/health coverage during my absence. I understand the college's obligation to continue to contribute to my health coverage ends when:
   a) I choose not to retain health coverage during my FMLA Leave absence as I have indicated above; or
   b) I fail to return from leave upon schedule, or I inform my Agency of my intent not to return.
   (Upon separation from employment, COBRA insurance continuation provisions may apply.)
2. I understand that if I choose to continue my insurance as indicated above, my premium is due by the first of the month for the month of coverage (check made out for the above specified total to the Department of Administrative Services, and delivered to my Agency's Personnel Officer). If my premium is not remitted by the first calendar day of the month, my coverage will be suspended until my payment is received. If my payment is not received by the last calendar day of the month, my coverage will be terminated permanently until my return to work.
3. I understand that while on leave, I will have the same opportunities as other employees to change coverage, plans or benefits (open enrollment opportunities, for example).
4. I understand the State may recover the State contributions made on my behalf should I fail to return to work after my FMLA Leave entitlement expires, unless the reason I fail to return is due to:
   a) A continuation, recurrence, or onset of a serious health condition which would entitle me to leave under the Family and Medical Leave Act; or
   b) Other circumstances beyond my control as defined in the Family and Medical Leav

Signature | Date

For Administrative Use Only:

Date received

HR signature | Date