CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE
HEALTH BENEFITS CONTINUATION BIWEEKLY PREMIUM SCHEDULE
(PRINT OR TYPE ONLY)

Name: _____ _____-_____-_____
Last First MI. Social Security Number

_____ (_____)_____-_____
Address City St. Zip Code Home Phone Number

_____ _____ _____/_____/_____
Employee Number Department Name Date of Last City Payroll Check Received

CONTINUED GROUP HEALTH PLAN INSURANCE COVERAGE

(Note: Workers' Compensation does not pay for benefits while an employee is out on injury.)

I acknowledge that while I am on FMLA, I am responsible for my share of the premium payment for my group health plan coverage and the premiums for continuation of any other benefit(s) I wish to maintain. I understand that failure to make this payment within thirty (30) days of the due date will result in termination of health plan and other coverage retroactive to the date for which my last premium was paid. If coverage is terminated due to non-payment or untimely premium payment, I understand that my health plan and other coverage will be restored without requalification upon my return to work and my completion of enrollment forms on the same terms as prior to my leave.

SECTION I - ELECTION

I am paying for the period of _____, and I agree to pay for my benefits below (check applicable boxes):

Please use chart on the reverse of this form to calculate your Basic Life Insurance Premium of one times your annual salary.

(BIWEEKLY PREMIUMS)	MEDICAL PREMIUM	DENTAL PREMIUM	BASIC LIFE PREMIUM	TOTAL PREMIUM
HMO				
Employee only	{___} $ 18.13	{___} $ 4.50 DHMO		
(Medical Tobacco Rate)	{___} $ 30.63	{___} $ 13.62 INDEMNITY	$ _____	$ _____
Employee + One Dependent	{___} $ 99.68	{___} $ 9.70 DHMO		
(Medical Tobacco Rate)	{___} $ 112.18	{___} $ 31.50 INDEMNITY	$ _____	$ _____
Employee + Two or More Dep.	{___} $ 122.39	{___} $ 13.73 DHMO		
(Medical Tobacco Rate)	{___} $ 134.89	{___} $ 42.95 INDEMNITY	$ _____	$ _____
PPO & Out-of-Area				
Employee only	{___} $ 124.80	{___} $ 4.50 DHMO		
(Medical Tobacco Rate)	{___} $ 137.30	{___} $ 13.62 INDEMNITY	$ _____	$ _____
Employee + One Dependent	{___} $ 356.90	{___} $ 9.70 DHMO		
(Medical Tobacco Rate)	{___} $ 369.40	{___} $ 31.50 INDEMNITY	$ _____	$ _____
Employee + Two or More Dep.	{___} $ 460.61	{___} $ 13.73 DHMO		
(Medical Tobacco Rate)	{___} $ 473.11	{___} $ 42.95 INDEMNITY	$ _____	$ _____

Voluntary Life Insurance with John Hancock and/or General American should also be included in the total premium amount. Enter your biweekly premium here: General American $_____ John Hancock $ _____. (Premiums are located on your check stub.)

TOTAL AMOUNT ENCLOSED: $_____

SECTION II - ELECTION

☐ I elect **NOT** to continue my group health plan coverage or any other benefit coverage while on unpaid FMLA.

Premiums must be paid by **CASHIERS CHECK OR MONEY ORDER ONLY**. Payment will be made payable to: **City of Houston Health Benefits**. Premium payments must be in the **Human Resources Department, Benefits Division, LWOP Section, 611 Walker, 4th Fl., Houston, TX 77002,** by the first (1st) and fifteenth (15th) of the month. A copy of this form must be attached to your payment. (Monthly payments can also be made.)

I have reviewed and understand my responsibilities regarding my portion of the premium payments for group health plan insurance coverage and other benefits coverage while I am on Family Medical Leave.

Signature: _____ Date: _____/_____/_____

BASIC LIFE INSURANCE

FORMULA FOR CALCULATING BASIC LIFE PREMIUM

STEP 1.)

Enter your biweekly base pay and multiply it by twenty-six (26) to arrive at your annual salary. Take your annual salary amount and round it to the nearest thousand (example: Annual salary $22,550.55 = nearest thousand is $23,000). Divide nearest amount by one thousand to arrive at value amount (*).

_____	x 26 =	_____	=	_____	÷ 1,000 =	(*) _____
Biweekly Base Pay		1 Times Annual Salary		Round Salary to nearest Thousand		Value Amount

STEP 2.)

Carry value amount to this space (*) and multiply by sixteen cents (.16). This is your total monthly Basic Life Premium. Divide your total monthly basic life premium by two (2). This is your Basic Life Biweekly Premium. ***(Place this amount on Basic Life column on reverse side.)***

(*) _____	x .16 =	_____	÷ 2 =	_____
Value Amount		Total Monthly Basic Life Premium		Basic Life Biweekly Premium

Please carry Basic Life Biweekly Premium to the reverse side of this form for calculation with your other benefits.

<u>Other Benefits Coverage: AFLAC (American Family Assurance Company)</u>

Your AFLAC supplemental insurance policy (ies) may also be maintained by:

- Informing your Department that you wish to continue premiums for AFLAC.
- Making premium payments for each policy that you may have.
- Payments for AFLAC will be made along with your benefits payment.

Payments will be made payable to AFLAC by a separate money order or cashier check. One money order or cashier check may be used to pay for all AFLAC policies. Payments for AFLAC will be made with your medical, dental, and life insurance payment.

If you have questions or need any assistance regarding your benefits or calculating your premiums, please contact the Benefits Office at (713) 837-9400.