BCF solutions

Insurance Premium Recovery Authorization Form

To: Human Resources

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

I acknowledge BCF's legal right to recover the cost of any premium 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 continuation, recurrence, or onset of a serious health condition that entitles me to leave to care for a family member 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 that prevent me from returning.

Name (print): Date:

Name (sign): Employee No:

Insurance Premium 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 excepted above, I agree to coordinate with BCF to develop a mutually acceptable schedule to reimburse BCF for any premium it paid to maintain my coverage in group health benefits during any period of unpaid leave I took.

Name (print): Date:

Name (sign): Employee No:

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