COUNTY OF SANTA CRUZ

PERSONNEL DEPARTMENT
AJITA PATEL, DIRECTOR
701 OCEAN STREET, SUITE 510, SANTA CRUZ, CA 95060-4073
(831) 454-2600 FAX: (831) 454-2411 TDD: 711

EMPLOYEE REQUEST FOR REIMBURSEMENT OF COUNTY MEDICAL CONTRIBUTION

Employee Name: _____ Employee Number: _____
(*Print*)

Address: _____
(*Street, City, State, Zip Code*)

I am/or will be on a leave of absence and am electing to continue health coverage for myself (and my dependent(s), if currently enrolled) through the CalPERS Direct Pay Authorization Policy. My type of Leave of Absence is/will be:

☐ FMLA/CFRA/PDL ☐ Workers' Comp ☐ Other Medical

Proof of Direct Pay to the health plan must accompany this request form in order for the reimbursement to be processed. Proof of payment is defined as a copy of a cancelled check, a copy of a bank or credit card statement which indicates the date of payment, amount of payment, and the payee.

For FMLA/CFRA/PDL, or Workers' Comp Leaves, the County will reimburse the employee for the same contribution amount as if the employee were actively working or on paid leave.

If the employee is not entitled to FMLA/CFRA/PDL, or Workers' Comp Leave or the leave has extended beyond the duration of the approved FMLA/CFRA/PDL or Workers' Comp Leave, the County contribution towards **employee-only** medical will be reimbursed (there is no reimbursement for the dependent(s) coverage)

Requests for reimbursement of County medical contribution should be made each month and will not be considered eligible for reimbursement after 90 days have lapsed from the date the payment was processed. Please mail this form to: Benefits Unit 701 Ocean St., Room 510, Santa Cruz, CA 95060. Allow 2 weeks for processing of the reimbursement request.

_____
Employee Signature Date

For Benefits Division Use Only:

Health Plan: _____ # of dependents: _____ Keying Group: _____ Benefit Status: _____

Month / Year Paid: _____ Amount Paid: _____ Amount Reimbursed: _____

Index #: _____ Analyst Approval: _____ Date: _____