COUNTY OF SANTA CRUZ

HUMAN RESOURCES DEPARTMENT
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EMPLOYEE REQUEST FOR REIMBURSEMENT OF COUNTY MEDICAL CONTRIBUTION

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

Complete Mailing Address: _____

I am/or will be on a Leave of Absence and have elected 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:

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

Proof of Direct Pay to the health plan must accompany this request form for the reimbursement to be processed. Proof of payment is one that demonstrates your payment was successfully processed by your financial institution. This can be defined as: a copy of the front and back of a cancelled check; a copy of a bank or credit card statement that identifies you as the payee, with the date and payment amount successfully processed.

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 may 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., Suite 510, Santa Cruz, CA 95060. Allow 10 business days 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: _____