CITY OF OXNARD CALIFORNIA

Acknowledgement of Payment of Insurance Costs During Leave of Absence

Employee Name (print):	Employee ID #:
Employee phone #:	Employee email:
Date leave began:	Anticipated return to work date:

I, _____ (Employee Name), am requesting a Leave of Absence for the dates noted above. I understand that a leave of absence under the Family and Medical Leave Act (FMLA), the California Family Rights Act (CFRA), or the Pregnancy Disability Leave (PDL) are **unpaid** leaves and I must use my own accrued leave time during my leave of absence. I also understand that if I am a member of SEIU or IUOE, I may be eligible for State Disability Insurance (**SDI**) or Paid Family Leave (**PFL**) benefits through EDD but that I must file directly with EDD for those benefits. I understand that if I am a member of OMMA or Executive unions, I may be eligible for Short Term Disability (**STD**) benefits through The Standard but that I must file directly with The Standard for those benefits. I understand that I may elect to use my accrued leave time to supplement my pay from EDD (for SEIU or IUOE only) or The Standard (for OMMA & Executive only). **I further understand that if/when my accrued leave time has exhausted, I will be responsible for paying all of my health insurance premiums directly.**

DURING MY LEAVE OF ABSENCE (LOA):

I ☐ **will** be applying for: ☐ SDI ☐ PFL ☐ STD ☐ American Fidelity ☐ Other (please list):_____

I ☐ **will not** be applying for any disability or PFL benefits and will use my full accrued leave time during my LOA.

IF YOU ARE APPLYING FOR DISABILITY OR PFL BENEFITS, DO YOU WANT TO SUPPLEMENT THESE BENEFITS WITH YOUR PERSONAL ACCRUED LEAVE TIME?

☐ Yes (mark one of the supplementing options below):
- ☐ I want to supplement to cover only my deductions throughout my leave of absence.
- ☐ I want to supplement to cover my deductions only until I receive my benefits notice and then use my accrued leave time to make myself whole. **(Must provide HR a copy of your benefits notice.)**

☐ No. I do not want to supplement and will pay for all my health insurance deductions directly. (Must complete the *Direct Payment Authorization Form*.)

Please use my following leave banks in the order indicated:

Sick Leave #___ Vacation Leave #___ Annual Leave #___ Admin Leave #___ Comp Time #___

☐ This is a **Military Leave** and I am a member of ☐ IAFF ☐ OPOA ☐ Other (please list):_____

By signing below, I agree to all of the foregoing.

_____ _____

Employee Signature Date

cc Payroll: