University Family Medical Leave (UFML) – Premium Reimbursement Claim Form for Unpaid Leave

Overview and Purpose Of Reimbursement Plan

During a period of **unpaid** University Family Medical Leave (UFML) for the care of a registered, same-sex, domestic partner, employees will be billed for the **total** State of Illinois Central Management Services (CMS) insurance premium (including both the employer-paid portion and the employee-paid portion of the premium) and are responsible for keeping premium payments current. The purpose of this reimbursement plan is to reimburse the employee for the employer portion of the premiums incurred during an approved unpaid UFML leave. This reimbursement is a taxable benefit subject to the applicable tax withholdings. CMS must have received payment of entire bill before reimbursement is processed. This form is not to be used for any other purpose. When completing this document, please print.

Employee Information

Name _____ Employee ID _____
Last First Middle Initial

Home Address _____
Street Apartment

_____ Day Phone ( ) _____
City State Zip Code

Premium Information

So that we may process your claim as quickly as possible, please attach the following documentation with this form:

- Copy of Central Management Services (CMS) monthly bill(s)

The Benefits Service Center must verify receipt of payment before reimbursement is processed.

Employee Authorization

I understand that providing false information on this form may result in disciplinary action up to and including termination of employment. I agree that if this were to occur, the University may recover damages for all losses and reasonable attorney's fees incurred by the University to recover such damages.

_____ _____
Employee's Signature Date

Urbana Campus
Benefits Service Center
807 South Wright Street
480 IUB, MC-311
Champaign, Illinois 61820

Chicago Campus
Benefits Service Center
715 South Wood Street
305 HRB, MC-524
Chicago, Illinois 60612

Springfield Campus
Benefits Service Center
One University Plaza, HRB 30
Springfield, Illinois 62703-5407

TO BE COMPLETED BY BENEFITS SERVICE CENTER AND PAYROLL STAFF ONLY

Based on the following questions, and the information above, does this employee qualify for reimbursement?

a. Was this individual on approved UFML during the time that he/she is requesting reimbursement? Yes No
b. Was the CMS bill paid in full? Yes No

If the answer to either of the above questions is No, then this employee does not qualify for reimbursement.

If the answer to both questions is Yes, please complete the following information, except for the Total Reimbursement field, and forward to Payroll for processing.

Month _____ Bill Amount* $ _____ Employer Cost $ _____ Total Reimbursement $ _____
(to be completed by Payroll)

Month\ _____ Bill Amount* $ _____ Employer Cost $ _____ Total Reimbursement $ _____
(to be completed by Payroll)

_____ _____
Authorizing Signature - Benefits Date

Date Benefits Service Center sent request for reimbursement to Payroll: _____
Date

Copy of completed document should be provided to employee.

**Only includes premiums for Health, Dental & Basic Life Insurance.* *8/2009*