a **AM 205-4-2**

m Notification of Employee Indebtedness Health Insurance Premium (Memo to the Employee)

FROM: Department of Human Resources - Employee Benefits Division ("EBD")

TO: (Employee): _____

DATE: _____

RE: Employee Indebtedness – Health Insurance Premium

Our records indicate that you owe a total of $ _____ for your health insurance premiums while you were in out-of-pay status. Please see Section I: Repayment Options below for your available repayment options.

You have ten (10) business days to notify EBD in writing if you wish to contest the validity of the premium owed. You must provide an explanation and documentation to substantiate your claim.

Section I: Repayment Options

The following options are available to you for health insurance payment:

- Regular employees with annual base salaries of $60,000 or more: **$100 per pay cycle**.
- Regular employees with annual base salaries of $60,000 or less: **$50 per pay cycle**.
- Regular employees paid on a weekly basis: **$25 per week**.
- Double deduction of the health insurance premium owed until debt is paid in full.

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If you do not voluntarily elect to enroll in the payroll deduction plan and return this Memo to EBD within two weeks of your return, a double deduction of the insurance premiums will occur until the debt is paid in full.

Please check the appropriate box above and sign Sections II and III to acknowledge this notification.

Section II: Acknowledgement

If, after ten (10) business days from when the Agency notified the employee of an overpayment, EBD has not received a letter of protest, a signed installment election form, the uncashed erroneous paycheck, or an employee's personal check or money order for the net amount of the overpayment, EBD will proceed with recovery via payroll deduction. Recovery in this circumstance will be made until the owed premium is fully satisfied.

Employee's Signature: _____ **Date:** _____

Original to Employee
Employee's File
EBD Copy

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Section III: Installment Election Form

Employee's Name (Printed): _____

I authorize the City of Baltimore ("City") to deduct $_____ per pay period from my payroll check starting from next pay period. I understand and agree that I am responsible for satisfying the above amount. I understand and agree that any amount that is outstanding and due at this time during my leave without pay status will be deducted from my payroll check until it is paid in full.

Employee's Signature: _____ Date: _____

Agency Representative: _____ Date: _____