FMLA LEAVE INVOICE

INVOICE #

EMPLOYEE INFORMATION

Name:

ID #:

Department:

BILLING DETAILS

Date Issued:

Leave Period:

Due Date:

Description (Benefit/Coverage)	Coverage Period	Employee Share	Employer Share	Total Due
Health Insurance Premium				
Dental / Vision				
Life Insurance / Supplemental				
Other:				
			Total Amount Due From Employee:	

PAYMENT INSTRUCTIONS & NOTES

Please make checks payable to:

Remit to:

Notice: Under the Family and Medical Leave Act (FMLA), employees on unpaid leave may be required to pay their share of group health insurance premiums to maintain coverage. Failure to remit payment by the due date may result in loss of coverage.