REQUEST FOR BENEFITS DURING LEAVE

Month of Coverage_____ **Year** _____ **Payment Due Date** _____

Select Type of Leave*

- ❑ FMLA with Pay
- ❑ FMLA without Pay
- ❑ Leave of Absence with Pay
- ❑ Leave of Absence without Pay

Select Level of Coverage(s) Requested

Type	Amount Due	Eligible for Payroll Deduction ** 1st pay	2nd pay
❑ Health	$_____	Yes No	Yes No
❑ Prescription	$_____	Yes No	Yes No
❑ Vision	$_____	Yes No	Yes No
❑ Dental	$_____	Yes No	Yes No
❑ Life	$_____		

* Double check status changes during month when completing types of leave.
** Payroll Deductions can only be made if a paycheck will be received during leave on the first ***and*** second pay of the month.

To continue benefits, payment(s) are due by the last day of the month prior to coverage. Failure to pay premium(s) will result in termination of coverage(s). Refer to the Family Medical Leave policy for more information.

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Employee Signature _____ Date _____

Supervisor Signature/_____ Date _____
Insurance Representative Signature

Return copy with monthly insurance report