



Leave Application for Continuation of Group Benefits

For FMLA/PFL:

Before completing, please read documents titled ["Information on Continuation of Benefits While on FMLA/PFL"](#) and [FMLA/PFL Rates](#)

For LOA (non-FMLA/PFL):

Before completing, please read documents titled ["Information on Continuation of Benefits While on Leave of Absence"](#) and [LOA Rates](#)

Employee's Name _____

Employee Number _____

Address _____

Telephone Number: _____

Campus: _____

Leave Period: From _____ To _____

Continue:

_____ **Health Insurance**

FMLA/PFL: The employee share of the biweekly premium must be paid for continuation of Health Insurance.

LOA : The full biweekly premium must be paid for continuation of Health Insurance.

_____ **Dental Insurance**

FMLA/PFL: The employee share of the biweekly premium must be paid for continuation of Dental Insurance.

LOA: The full biweekly premium must be paid for continuation of Dental Insurance.

_____ **Vision**

FMLA/PFL: The employee share of the biweekly premium must be paid for continuation of Vision Insurance. (if applicable)

LOA: The full biweekly premium must be paid for continuation of Vision Insurance.

_____ **Basic Life Insurance**

Basic Life continuation requires payment of the Foundation premium.

_____ **Optional Life Insurance**

Optional Life Insurance continuation requires payment of the employee premium.

*** A copy of the approved Employee Request for Leave must be attached.**