Dartmouth
Benefits Office, Human Resources

7 Lebanon St., Suite 203
Hanover, NH 03755
(603) 646-3588
Human.Resources.Benefits@dartmouth.edu

Application for Unpaid Leave of Absence / Leave Own Charges

Leave of Absence (LOA) is unpaid leave for staff. Leave Own Charges (LOC) is unpaid leave for faculty.

1. Employee: leave request

Please complete sections 1, 3, and 4. Faculty must first contact the Dean of Faculty Fiscal Office for completion of appropriate additional paperwork.

Name _____ Dartmouth ID _____

Position _____ Department _____

Telephone _____ Email address _____

Is this leave a continuation request? ○ Yes ○ No

Expected date to begin leave _____ Expected date of return _____

Reason for leave _____

Employee signature _____ Date _____

2. Department authorization

This section is to be completed by the Department and forwarded to the Benefits Office at Human.Resources.Benefits@dartmouth.edu. By signing this form, you are approving the unpaid absence of this individual as listed above. This form removes this faculty/staff member from the payroll. Pay will be reinstated as of the expected return date unless notified otherwise. Please notify the Benefits Office as soon as possible if these dates change or if you have questions.

I have reviewed and understand the request made by the employee. Endorsement of this application is made with the understanding that the employee:

○ is expected to return to the position at the expiration of the leave

○ is not expected to return to the position at the expiration of the leave

Supervisor

Name _____ Signature _____ Date _____

Department head

Name _____ Signature _____ Date _____

Fiscal officer

Name _____ Signature _____ Date _____

Local HR / HR Business Partner

Name _____ Signature _____ Date _____

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3. Employee: benefit elections while on leave

Please read and initial at the bottom that you understand and agree to the terms.

While on leave, you will have the option to either continue or cancel each of your previously elected benefits.

If you do not complete section 4, we will automatically continue your benefits and you will be billed the full cost of your benefits.

If your leave period carries over into the next calendar year, you will be responsible for completing your annual open enrollment elections during the annual open enrollment period. Some benefits may carry over automatically, others like FSAs will not. Some cancelled benefits may automatically be reinstated upon your return.

Employee initials ☐

4. Employee: continue or cancel benefits

Please indicate below which benefits you wish to cancel or continue during your leave period, and sign the section to show that you understand and agree to the terms. Medical, dental, life, and disability benefits will be recalculated and reinstated upon your return. DCFSA, HCFSA, and HSA benefits will only be recalculated and reinstated when returning within the same calendar year. Changes for the following calendar year should be made during the annual open enrollment period.

I wish to CONTINUE the following benefits:

- ☐ Medical
- ☐ Employee Life Insurance
- ☐ Accident Insurance
- ☐ Hospital Indemnity
- ☐ Long-Term Disability (LTD), note A
- ☐ Dental
- ☐ Dependent Life Insurance
- ☐ Critical Illness Insurance
- ☐ Vision Coverage
- ☐ Health Savings Account (HSA), note B

A. LTD premiums will be collected upon your return, due to post-tax payment restrictions.
B. You may continue to contribute to a Health Savings Account on a post-tax basis while on leave. You may then claim pre-tax status when filing your tax returns at year end. Remember to count any post-tax contributions toward the annual contribution limit.

I agree to pay promptly and in full for the amounts billed monthly. I understand that if I do not make full payment each month, within 25 days of the due date, my benefits will be cancelled, and I will be responsible for the outstanding balance, a finance charge of 1.5% per month, and any collection or attorney costs incurred in collecting the balance due. Upon my return, if there is any outstanding balance, I authorize the College to collect overdue amounts including finance charges, through payroll deduction.

Signature for monthly billing ☐ Date ☐

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I wish to CANCEL the following benefits:

The Health Care FSA and Dependent Care FSA are checked because they are canceled automatically while you are on leave.

- ☐ Medical
- ☐ Employee Life Insurance, note C
- ☐ Accident Insurance
- ☐ Hospital Indemnity
- ☐ Health Savings Account (HSA)
- ☑ Health Care FSA (HCFSA), note D
- ☐ Dental
- ☐ Dependent Life Insurance, note C
- ☐ Critical Illness Insurance
- ☐ Vision Coverage
- ☐ Long-Term Disability (LTD)
- ☑ Dependent Care FSA (DCFSA), note E

C. If you cancel your supplemental employee or dependent life insurance, you will be treated as enrolling for the first time when you return, and a new Evidence of Insurability (EOI) application will be required.

D. IRS rules prohibit post-tax contributions to a HCFSA.

E. IRS rules prohibit contributions to a DCFSA while the employee and/or their spouse are not actively working.

Signature for canceling benefits _____ Date _____

Please ensure that your legal mailing address is current at https://employee.dartmouth.edu

For Human Resources Benefits use only

☐ FMLA ☐ MILTRY ☐ HRMS ☐ FLEX ☐ A/R ☐ EE

Signature _____ Date _____

Comments _____