DARTMOUTH COLLEGE
APPLICATION FOR FAMILY/MEDICAL LEAVE

Name: _____ Department: _____

Current Address: _____

Telephone: _____ Dart ID Number _____

Supervisor Name: _____

Start Date of Anticipated Leave: _____

Expected Date of Return to Work: _____

Will you be paid for vacation and/or personal leave during this time? If so, what dates_____

Will this leave be intermittent? Is so, what dates do you expect to be out of work?

_____

Reason for Leave (check one):

_____The birth of a child, or placement of a child with you for adoption or foster care; or

_____A serious health condition that makes you unable to perform the essential functions for your job; or

_____A serious health condition affecting _____your spouse, _____your child, _____your parent for whom you are needed to provide care.

_____

_____

Benefit Elections While on Unpaid Family/Medical Leave

Complete only if your leave is unpaid

BENEFIT ELECTIONS: *If FML is approved, Dartmouth College continues your benefit credit. You have the option of continuing or canceling your benefits. Upon return from your leave, your cancelled benefits will be reinstated automatically by the Benefits Office.*

I wish to continue the following benefits during my leave:

☐ Medical ☐ Dental ☐ Employee Life Insurance ☐ Dependent Life Insurance

☐ Health Care Reimbursement Account

Dependent Care Reimbursement Accounts cannot be continued while on leave according to IRS regulations.

I wish to cancel the following benefits during my leave:

☐ Medical ☐ Dental ☐ Employee Life Insurance ☐ Dependent Life Insurance

☐ Health Care Reimbursement Account

PAYMENT ELECTIONS

☐ I will continue to receive regular paychecks less unpaid Family Medical Leave hours. My benefits will continue to be deducted from my paycheck. Check this if you are going on short-term disability or using PTO while on FML

☐ I wish to make payment at this time.
(*Please contact the Benefits Office at (603) 646-3588 for payment amount.*)

☐ Please bill me on a monthly basis at the following address: _____

_____

_____

I agree to pay 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, that my benefits will be cancelled. I understand 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.

Note: An employee requesting leave for the employee's serious health condition or the serious health condition of the employee's spouse, child or parent must submit a verifying Medical Certification from the physician within 15 days of the application for leave.

I understand that failure to return to work at the end of my leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by Dartmouth College.

Signature: _____ Date: _____
(***Required***)

Approved by:

Human Resources Representative:

_____ Date: _____

Return to:

HR **The Office of Human Resources at Dartmouth College**
7 Lebanon Street • Suite 203 • Hanover • New Hampshire • 03755-2112
Telephone: (603)646-3588
Fax: (603)646-1108