DARTMOUTH
Benefits Office, Human Resources

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603-646-3588
human.resources.benefits@dartmouth.edu

APPLICATION FOR HIATUS LEAVE

Hiatus Employee = Biweekly paid employee who holds a regular benefits eligible position that is less than 12 months each year.
Amortizing Benefits = Paying full cost of benefits for the hiatus period, during the 9, 10 or 11 months that you are actively working.

DO YOU AMORTIZE YOUR BENEFITS?

❒ **YES**, If you amortized benefits this year, you do not need to complete this form.

❒ **NO**, If you are new to Dartmouth and/or did not amortize your benefits this year, please complete this form and give it to your Supervisor, prior to the start of your leave. ***Sections 1, and 2 are to be completed by the employee.***

1. EMPLOYEE: Please complete this form prior to departing for your hiatus period.

Name: _____ Dartmouth ID: _____

Position: _____ Department: _____ Telephone: _____

Expected date to begin leave: _____ Expected date of return: _____

2. BENEFIT ELECTIONS WHILE ON HIATUS:

While on Hiatus, you will have the option to **continue** your benefits or **cancel** them. 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 ☐ Dental ☐ Employee Life Insurance ☐ Dependent Life Insurance
☐ LTD[A] ☐ Health Savings Account[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 while on leave, through Fidelity on a post-tax basis. 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 understand that I am responsible for the full cost of the premium ***(no medical credit will be received during this leave)***. I agree to pay promptly and in full for any amounts billed monthly. Upon my return, if there is any outstanding balance, I authorize the College to collect overdue amounts through payroll deduction.

Signature for Monthly Billing: _____ Date: _____

I wish to CANCEL the following benefits:

☐ Medical ☐ Dental ☐ Employee Life Insurance[A] ☐ Dependent Life Insurance
☑ Health Care FSA[B] ☑ Dependent Care FSA[C] ☐ Health Savings Account ☐ LTD

A. You may re-enroll in supplemental life insurance without re-application of EOI and approval from MetLife *if you return within six months.*
B. You may not contribute to a Health Care FSA on a post-tax basis.
C. Per IRS regulations, you may not contribute to a DCFSA when not actively working.

Signature for cancelling benefits: _____ **Date:** _____

3. DEPARTMENT AUTHORIZATION:

Supervisors, please sign and return to the Human Resources Benefits Office. If you have any questions, please contact Human Resources Benefits at 603-646-3588 or at Human.Resources.Benefits@Dartmouth.edu

Name: _____ **Signature:** _____ **Date:** _____

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