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) = Staff, unpaid leave *Leave Own Charged (LOC) = Faculty, unpaid leave*

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

Name: _____ Dartmouth ID: _____

Position: _____ Department: _____ Telephone: _____

Is this leave a continuation request? _____ Email Address: _____

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 or _____IS NOT expected to return to the position at the expiration of the leave.

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

Dept. Head Name:_____ **Signature:** _____ **Date:** _____

Fiscal Officer: _____ **Signature:** _____ **Date:** _____

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 on the next page, 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 carryover automatically, others like FSA's will not. Some cancelled benefits may automatically be reinstated upon your return.

Employee Initials: _____

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

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4. EMPLOYEE:
Please indicate below which benefits you wish to Cancel or Continue during your leave period and sign the section indicating 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 ☐ Dental ☐ Employee Life Insurance ☐ Dependent Life Insurance
☐ Accident Insurance ☐ Critical Illness Insurance ☐ Hospital Indemnity
☐ LTD[A] ☐ Health Savings Account[B] ☐ Vision Coverage

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 through Fidelity 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: _____

I wish to CANCEL the following benefits:

☐ Medical ☐ Dental ☐ Employee Life Insurance[A] ☐ Dependent Life Insurance
☐ Accident Insurance ☐ Critical Illness Insurance ☐ Hospital Indemnity
☑ Health Care FSA[B] ☑ Dependent Care FSA[C] ☐ Health Savings Account
☐ Vision Coverage ☐ 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. IRS rules prohibit post-tax contributions to a HCFSA.
C. IRS rules prohibit contributions to a DCFSA while the employee and/or their spouse are not actively working.

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

HUMAN RESOURCES BENEFITS

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

Signature: _____ Date: _____

Revised 3/27/25

COMMENTS:

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