Clear Form

Polk County
Leave of Absence Benefit Continuation Form

1. Employee's Name	2. Employee Payroll Number (5 digit)
3. Position	**4. Department**

5. Type of Leave Requested (check each that applies)

☐ FMLA/Medical ☐ Military ☐ Worker's Comp ☐ Other: _____

Reason for Requested Leave:			
Start Date (first day of leave):		Last Date worked:	
Expected return to work date*:			

*You are responsible for contacting your supervisor and HR with changes in this date.

6. Short Term Disability (STD) / Long Term Disability (LTD):

Eligible employees are covered by LTD after a 90 day elimination period. The benefit paid is 60% of the employee's base earnings. Employees are required to use accrued paid leave during this 90 day elimination period, unless you purchased Short Term Disability insurance. Employees who do not have enough accrued paid leave to cover the 90-day elimination period, must utilize all their leave prior to being placed in an unpaid status.

☐ STD purchased by employee (please complete section 7)

☐ STD waived by employee (please skip to section 8)

Employee's are not eligible for Long Term Disability when on military leave or paid worker's compensation benefits. Upon an employee's return to active employment LTD benefits will be reinstated.

7. Pay during approved STD (choose one option):

☐ Unpaid: No accrued leave used. Applicable deductions must be paid to Human Resources on the first of each month.

☐ Partially Paid: Please use the following hours of accrued paid leave per pay period. This will be used to cover any applicable deductions.

_____ Sick Leave _____ Vacation _____ Personal _____ Compensatory

☐ Fully Paid: Accrued leave will be used and benefit deductions (indicated below) will be deducted each pay period.

8. Benefit Elections:

Enrolled	Description	Continue Insurance?		Monthly Premium
☐	Health Insurance	☐ Y	☐ N	
☐	Dental Insurance	☐ Y	☐ N	
☐	Vision Insurance	☐ Y	☐ N	
☐	EMC Supplemental Life Insurance	☐ Y	☐ N	
☐	Principal GUL Life Insurance	☐ Y	☐ N	
☐	Dependent Life Insurance	☐ Y	☐ N	
☐	457/401(a) Deferred Compensation *	☐ Y	☐ N	
☐	Flexible Spending Accounts (Health Care and/or Dependent Care)	☐ Y	☐ N	

**These benefits cannot be continued when an employee's status is unpaid. Deferred Compensation deductions will automatically be stopped if employee is unpaid and employee must contact Human Resources within 31 days of returning to work to resume this deduction.*

9. Payment Election:

☐ Payroll Deduction

☐ Monthly Direct Pay

☐ Lump Sum Payment prior to Leave begin date.

☐ Arrangement made with Central Accounting as stated below:

10. Acknowledgement

I have read and understand the following:

- I will be responsible to pay for all benefit premiums while on any approved leave of absence. If premiums are not paid, insurance may be cancelled for non-payment.
- If I do not return from FMLA leave for at least 30 calendar days due to reasons not provided in the Family and Medical Leave Act, then FMLA does not apply to this period of leave and I am required to reimburse all insurance premiums paid by Polk County during any periods of unpaid FMLA leave. If reimbursement is not made, insurance coverage will be cancelled retroactively to the first of the month following exhaustion of paid leave.
- If I choose to waive life insurance while on leave of absence, I and my covered dependents will be subject to underwriting approval before supplemental insurance can be reinstated.
- My annual FSA election may be adjusted for premiums not paid during my leave of absence unless I agree to make up the missed contributions upon my return to work.
- It is my responsibility to notify Human Resources upon my return to work in order to reinstate any applicable benefits.
- This election form can only be changed once each 30 calendar days.

Signature _____ Date: _____

Please call Lola Evans at 515-286-3203 if you have any questions.