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: _____

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. Benefit Elections: Please place a check mark next to the benefits you wish to continue during your absence.

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		
☐	AFLAC (short-term and/or Accident, Cancer, or Hospitalization)	☐ Y	☐ N		

**These benefits cannot be continued when an employee's status is unpaid or if being paid by Disability or Workers Compensation. Deferred Compensation deductions will automatically be stopped if employee meets the above criteria and employee must contact Human Resources within 31 days of returning to work to resume this deduction.*

7. Payment Election:

☐ Payroll Deduction *(Employees receiving Workers Compensation are not eligible for payroll deduction)*
☐ Lump Sum Payment prior to Leave begin date.
☐ Monthly Payment

Monthly premiums are due by the first of each month. Checks should be made payable to Polk County Treasurer and mailed to the following address:

Polk County Auditor
Attn: Payroll
111 Court Avenue, Room 315
Des Moines, Iowa 50309

8. 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 9)

☐ STD waived by employee (please skip to section 10)

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.

9. 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.

Employees who purchased Short-Term Disability insurance through AFLAC have the option to utilize or not utilize earned accrued leave(s) while receiving payment from AFLAC.

If you choose not to utilize any or only a few hours of accrued leave each pay period, it is your responsibility to pay all insurance/benefit premiums which are due. Additionally, your accruals for the time you are unpaid or partially paid will be adjusted *(see example below)*

***If you select unpaid**, you will be put into an "unpaid" status and not receive compensation during your leave period. Any sick, vacation, and/or personal time which normally is earned during the leave will **NOT** be credited to your leave balance. If a holiday falls within your leave of absence, you will NOT be paid for the holiday.*

***If you select partially paid**, you will be paid for the hours you elect. If you choose 20 hours per pay period to cover deductions, your sick, vacation and/or personal time which normally is earned will be prorated based on your scheduled hours. If a holiday falls within your leave of absence, you will be paid on a prorated basis.*

	Accruals earned based on 80 hours worked/paid per pay period	**Accruals earned based on 20 hours worked/paid per pay period**
Sick Leave	4.0 hours	1.0 hour
Vacation	2 weeks = 3.08 hours 3 weeks = 4.62 hours 4 weeks = 6.16 hours 5 weeks = 7.70 hours	2 weeks = .77 hours 3 weeks = 1.16 hours 4 weeks = 1.54 hours 5 weeks = 1.92 hours

10. Acknowledgement and Authorization:

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.

Signature _____ Date: _____

Please call Lola Evans at 515-286-3203 with any questions.