Unpaid Leave of Absence Request Form

An unpaid leave of absence is available in certain circumstances as described in Saint Petersburg College's on Unpaid Leave of Absence policy. Employees who meet the eligibility criteria for a leave of absence must complete this form at least 30 days prior to the commencement of leave or as soon as practicable in the event of an unforeseeable absence. Please note:

- All leaves of absence must be approved in advance by human resources (HR) and the employee's supervisor.
- If the dates of requested leave change, a new leave of absence request form must be submitted for approval.
- Employees on an unpaid leave of absence are responsible for payment of insurance premiums as agreed upon with HR prior to the commencement of leave.
- Employees returning from a leave of absence must contact HR at least one week in advance of the projected return date.

See Unpaid Leave of Absence policy for the full details on unpaid leaves of absence, including eligibility.
This form should not be used to request leave under the Family and Medical Leave Act (FMLA) or to request leave as an accommodation under the Americans with Disabilities Act (ADA). Employees should consult with HR to request leave under the FMLA or ADA.

Please complete this form and mail to Human Resources Benefits at Epi-services, room 148.

1. EMPLOYEE: *Please contact the Benefits Office to discuss benefits considerations prior to completing this form.* ***Sections 1, 3, and 4 are to be completed by the employee.***

Name:_____ID:_____
Position:_____Department:_____Telephone:_____
Expected date to begin leave [mm/dd/yyyy:]_____ Expected date of return [mm/dd/yyyy]: _____
Is this a leave continuation request:_____
Reason for Leave:_____
_____
_____
Employee Signature:_____Date:_____

2. DEPARTMENT: *Please contact your Human Resources Consultant prior to approving this form. This section is to be completed by the Department and submitted to Human Resources- Benefits. If you have questions, please contact the Human Resources Benefits Office at 727-341-3044*

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: _____

3. BENEFITS ELECTION WHILE ON LEAVE:
Before departing, you must complete this section to advise the Benefits Office of your benefit elections during your time away. If you do not make any elections, and you have medical insurance, dental insurance, or a Health Care Flexible Spending Account, you will automatically be billed for the full cost of the benefit(s).

BENEFIT ELECTIONS: *You have the option of **Continuing** your benefits or **Canceling** them. Upon return, you have the option of reinstating any benefits you had before your departure.*

I wish to **CONTINUE** the following benefits and understand that I am responsible for the full cost of the premium: (no medical credit will be received during this leave)

☐ Medical ☐ Dental ☐ Vision ☐ Employee Life Insurance ☐ Dependent/Spouse Life Insurance

☐ Health Care Flexible Spending Account [FSA]

[Dependent Care Flexible Spending Accounts cannot be continued while on leave according to IRS regulations.]

I wish to **CANCEL** the following benefits:

☐ Medical ☐ Dental ☐ Vision ☐ Employee Life Insurance ☐ Dependent/Spouse Life Insurance

☐ Health Care Flexible Spending Account [FSA]*

**Please note that canceling a Health Care Flexible Spending Account [FSA] will make the service period ineligible during the time that you are away. Claims can only be made against the account for services while the account is in effect. If you continue your account, any missed contributions may be deducted from your salary in your last paycheck before your departure in order to take advantage of the pre-tax opportunity.*

4. PAYMENT ELECTIONS:

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

Telephone number while on leave: _____
E-mail address while on leave:_____
I agree to pay promptly and in full for the amounts billed monthly by check to Jessica Sager at Business Office, Gibbs.
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, and I will be responsible for the outstanding balance.

I understand if I wish to cancel benefits while I am away, I must notify the Benefits Office in writing in advance of the date that I wish to cancel.

Signature required for monthly billing:_____Date:_____