



LEAVE OF ABSENCE FORM

(Please complete when enrolling employees who are on a Leave of Absence)

EMPLOYERS: *Please attach a copy of your Leave of Absence Policy*

Group Name:	Group LOA Policy (Select One for Each LOA Type): Personal LOA (Maximum Allowable is 3 Months) <input type="checkbox"/> None <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months Medical LOA (Maximum Allowable is 6 Months) <input type="checkbox"/> None <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 4 months <input type="checkbox"/> 5 months <input type="checkbox"/> 6 months
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Employee Name	First Date of Leave	Date Expected to Return	Reason for Leave <small>(Medical, Pregnancy, FMLA, Personal, Work Comp)</small>

NOTE: Employees who have reached the maximum allowable LOA and have not returned to work upon such date are eligible for COBRA benefits and shall be enrolled as such.

<p>I am the authorized representative of the above-named group and I certify that the above-named employees are on a Leave of Absence and are expected to return to work as indicated above.</p> <p>_____</p> <p>Authorized Signature _____ Date</p> <p>_____</p> <p>Title</p>	S I G N H E R E
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