



**CONTINUATION OF BENEFITS WHILE ON UNPAID LEAVE OF ABSENCE**

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_ DOB \_\_\_\_\_

SOC SEC # \_\_\_\_\_ DEPARTMENT \_\_\_\_\_ DAY PHONE \_\_\_\_\_

LAST DAY WORKED \_\_\_\_\_ DATE DUE TO RETURN \_\_\_\_\_

This form must be completed, signed by the faculty or staff member and returned to the Direct Billing Department prior to commencement of the unpaid leave. If form is received after commencement of the unpaid leave, then the changes elected below will begin the following month the form is received. Any faculty or staff member who is on an approved/unpaid leave will continue to receive benefits coverage under Vanderbilt's group plans at the level and under the conditions that such coverage would have been provided if the staff member had continued working. Once a department places a faculty or staff member on unpaid leave, he/she will begin receiving monthly billing statements for the staff member's portion of the premiums for all elected benefits until he/she returns to an active payroll status. While on unpaid leave, if a billing statement is not received, please contact Vanderbilt's Direct Billing Department at 615-322-3278. Premium payments must be made with a check or money order payable to Vanderbilt University and mailed to Vanderbilt University, Attn: Direct Billing, VU Station B 357700, 2301 Vanderbilt Place, Nashville, TN 37235-7700.

TYPE OF LEAVE (Check One)	BENEFIT PLAN (Please Check To Continue Or Cancel Each Plan)	CANCEL	CONTINUE
Medical	Medical*		
Personal	Dental		
Military	Basic Group Term Life		
Disability	Supplemental Life		
Other: _____	Accidental Death & Dismemberment (AD/D)		
	Long Term Disability (LTD)		
	Short Term Disability (STD)		
	Vision		
	Other: _____		

\*Cancelling medical coverage will result in loss of your FRA benefit and you will not be eligible to participate in the FRA plan in the future.

I hereby request Benefits to administer my insurance benefits in accordance with the instructions above. I agree to pay appropriate costs involved (including any necessary adjustments) and will notify Benefits of any change. I understand that my retirement plan contributions are based upon salary paid to me and will not be continued during my leave without pay.

**Premium payments are due on the 1<sup>st</sup> of each month in which coverage is to be provided. I understand that if my monthly premium payments are not received within thirty (30) days from the date due, then my benefits that I am electing to continue above will be terminated. I also understand that failure to receive a monthly billing statement does not relieve me of my responsibility of making timely premium payments. I acknowledge that this form is only applicable while I am on Leave Of Absence. Upon returning to work, I understand that if eligible, my benefit elections prior to my leave will be reinstated and hereby authorize Vanderbilt University to deduct in full from my next paycheck any remaining unpaid premiums, without further notice.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Address for mailing monthly statements:</b>
Telephone Number: (     )
E-Mail Address:

<b>Benefits Office Use Only:</b>
Empl ID:
Pay Group:
Check Number / Amount
Date To Processing Staff
Date To Direct Billing Staff