UNIVERSITY OF ILLINOIS SYSTEM

Leave of Absence Worksheet

Date: _____

Employee Information

UIN ☐☐☐☐☐☐☐☐ SSN: XXX-XX- ☐☐☐☐

First Name _____ Middle Name _____ Last Name _____

Home Address _____

City _____ State _____ Zip Code _____ Phone _____

Email _____

Department _____

Absence Information

☐ This is a new request. ☐ This is an update to an existing request.

Requested Start Date _____ Anticipated Return Date _____

Type of Leave

Below, please indicate the type of leave. Select either *State Paid Leave* or *Non-State Paid Leave* and the leave type from the list on the Information Form or contact University Payroll & Benefits office.

State Paid Leave _____

Non-State Paid Leave _____

State Insurance Plans

Keeping my current State Insurance Plan coverage(s)?

If **Yes**, CMS/MyBenefits will bill you monthly for the duration of your leave. **
If **No**, any benefit changes you wish to make will need to be completed in MyBenefits. Contact our office if you have questions. **

** If you are on a Non-State Paid Leave and elect to keep your insurance coverage, you are required to pay 100% of the employee **and** employer premiums.

State Benefit Change Options in MyBenefits

State Health/Dental/Vision Coverage
- ○ Full-Time Employees may Opting Out to drop State Health/Dental/Vision Coverage
- ○ Part-Time Employees may Waive to drop State Health/Dental/Vision Coverage
- ○ Terminate State health/dental/vision coverage (**Non-State Paid Leaves Only**) Re-Enrollment Required
- ○ I will be a dependent on my spouse's State of Illinois Group Insurance Plan (**Non-State Paid Leaves Only**)

State Life Insurance/Accidental Death & Dismemberment (AD&D)
- ○ Cancel Basic Life (**Non-State Paid Leaves Only**)
- ○ Cancel Employee Optional Life
- ○ Reduce Employee Optional to 1X, 2X, 3X 4X, 5X, 6X, 7X
- ○ Cancel All AD&D

Re-enrollment of dependent(s) is **not** automatic when you return to work. Use MyBenefits to enroll dependents into State health, dental and life. Contact our office for questions or additional information.

U of I System Plans (Accidental Death & Dismemberment, Life or Long Term Disability)

If you are currently enrolled in U of I System Plans, you will be billed monthly by University Payroll & Benefits. If you would like to cancel your U of I System Plans, please contact our office.

Acknowledgement

I acknowledge premiums, as established annually, will be deducted from my pay for those plans I have selected. I understand that if my paycheck is insufficient or if I am not on payroll, I will be direct billed by CMS/MyBenefits. The information contained in this form is complete and true. I agree to abide by all Group Insurance Program Rules. I agree to furnish additional information requested for enrollment or administration of the plan(s) I have elected. I understand it is my responsibility to review my paycheck and verify the amounts of the insurance deductions are accurate. I understand that if my deductions are not correct I must immediately contact University Payroll & Benefits. Falsification of the information contained on this form may result in discipline up to and including discharge. Additionally, CMS may impose a financial penalty, including, but not limited to, repayment of all premiums the Program made on behalf of the enrolled individual, as well as expenses incurred by the Program.

_____ _____

Employee's Signature Date

Complete, Print, Sign form and submit to University Payroll & Benefits office.

Email: obfsupbfcmleaves@uillinois.edu
Fax: 217-244-0993
Mail: University Payroll & Benefits
Fiscal Control Management Group
177 Henry Admin Building, MC-318
506 South Wright Street
Urbana, IL 61801

Questions?
Contact University Payroll & Benefits
Choose: "LOA Questions", when calling
UIUC 217-265-6363
UIC 312-996-7200
UIS 217-206-7144