

# REQUEST FOR LEAVE OF ABSENCE WITHOUT PAY

**FROM:**

NAME \_\_\_\_\_ EMPLOYEE ID# \_\_\_\_\_ JOB TITLE \_\_\_\_\_ DEPARTMENT \_\_\_\_\_

I am requesting a leave of absence without pay from:

\_\_\_\_\_  
FIRST DAY OFF SALARY

\_\_\_\_\_  
LAST DAY OFF SALARY

**REASON:** \_\_\_\_\_

**COMMENTS:** \_\_\_\_\_

**BENEFITS (Where applicable):**

- ▶ Please complete this section if you are enrolled in any of the following benefits. Please note, this is a generic form and lists all benefits. Only select those that apply to your situation.
- ▶ You must prepay where feasible, **both** your share and the grant's share of benefit premium costs of each benefit plan you choose to continue. **If you require detailed information about premium costs, select premium costs under your applicable business unit at [http://www.usask.ca/hrd/benefits/benefit\\_plans.php#rsrch](http://www.usask.ca/hrd/benefits/benefit_plans.php#rsrch) and/or refer to your paycheque.**
- ▶ If your final cheque, prior to your leave, is not large enough to cover the premiums for benefits, a billing arrangement will be made.
- ▶ Please indicate whether or not you want to maintain some, all or none of your benefit coverage while on leave. If you choose to continue any of your benefits, you must continue them for the full period of your leave of absence.
- ▶ For any leave, if you choose to cease your Supplemental Life Insurance coverage, coverage is terminated and you will have to reapply, providing medical evidence of insurability before coverage can be resumed.
- ▶ Maximum period to maintain benefits is 3 years

**BENEFIT PLAN**

**COVERAGE ELECTIONS**

|  |                              |                             |                                       |
|--|------------------------------|-----------------------------|---------------------------------------|
| Extended Health Care                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Enrolled |
| Dental   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Enrolled |
| Basic Group Life Insurance                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Enrolled |
| Supplemental Life Insurance                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Enrolled |
| Accidental Death & Dismemberment Insurance         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Enrolled |
| Spousal Supplemental Life Insurance                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Enrolled |
| Spousal Accidental Death & Dismemberment Insurance | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Enrolled |
| Salary Continuance Plan                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Enrolled |
| Research Pension Plan                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Enrolled |

APPLICANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

APPROVED BY:

(Principal Investigator)

DATE: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

Please forward this form along with a Job Information Form to Human Resources