Please complete this form to acknowledge the details of your leave of absence, and make your election on whether to continue your benefits coverages while on unpaid leave.

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| **EMPLOYEE INFORMATION** | | | |
| **Employee First Name** | **Employee Middle Name** | | **Employee Last Name** |
| **Employee’s Personal Email Address** | | **Employee’s Personal Phone Number** | |
| **Employee ID Number** | | **Agency Name** | |
| **LEAVE WITHOUT PAY** | | | |
| **Start Date** | | **End Date** | |
| **Reason:** | | | |

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| **CONTINUING ENROLLMENT AND AGREEING TO PAY THE PREMIUM OR INCUR A DEBT** |
| I understand that if I elect to continue coverage, I am responsible for paying my share of the premiums amounts for that coverage.  I understand that I must elect to pay a lump sum or incur a debt in the amount of the unpaid premiums.  I understand that coverage during a nonpay status will end at 365 days, unless I elect to terminate the coverage earlier by notifying my employing agency or the District of Columbia Department of Human Resources.  I understand that if I elect to pay a lump sum, I will submit payment to my agency’s human resources office upon my return by cashier’s check or money order payable to “D.C. Treasury”. I understand that I must include on the check:   1. My name, 2. My social security number, and 3. A note that the payment is for "FEHB premium" or “DCEHB premium” as appropriate.   I understand that if I elect to incur a debt, or if I elect to pay a lump sum but fail to pay the entire amount due, I will receive a notice stating the total amount due. The notice will be sent when I return to pay status, my pay becomes sufficient, or I separate from employment.  I understand that if I elect to incur a debt, I agree to pay fifty (50) dollars per pay period, for each benefit for which I owe premiums. This amount will be deducted from my District employee pay until the entire debt is paid in full.  I understand that by electing to continue coverage, I agree to repay the total resulting debt by allowing the District Government to collect the debt by withholdings from any salary payments. If the amount due cannot be withheld in full from salary, it will be recovered from any source normally available for the recovery of a debt due the District government.  I understand that if the total amount due cannot be withheld in full from my salary, deductions may be made from any wages, allowances, compensation, remuneration for services, or other authorized pay, including but not limited to back pay, severance pay, and lump sum leave payments, or from any source normally available for the recovery of a debt due the District government.  I understand that if I wish to continue non-FEHB or non-DCEHB benefits while in a nonpay status I will need to arrange with the provider to pay for those benefits directly if they are not doing so already. For employees who have AFLAC coverage, premium payments must be continued outside of payroll directly with AFLAC, or the employee’s AFLAC coverage will be discontinued after 60 days of nonpayment. |

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| **TERMINATING ENROLLMENT** |
| I understand that if I elect to terminate my enrollment, the termination will take effect at the end of the last pay period in which premiums were withheld from pay.  I understand that FEHB or DCEHB coverage, as applicable, will continue at no cost to me for an additional 31 days.  I understand that this termination does not make me ineligible for benefit coverage upon my return.  I understand that when I return to pay and duty status, or at the end of the first pay period, my pay becomes sufficient to cover my premium, I must reenroll within 31 days to restart FEHB or DCEHB coverage.  I understand that the period of lapse in coverage does not count toward satisfying the required five years of continuous coverage into retirement.  I further understand that my return will effect a new start date of enrollment, requiring five years of continuous service into retirement. |

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| **EMPLOYEE ACKNOWLEDGEMENT** | |
| I understand that failure to complete this form could result in termination of coverage.  I understand that I am expected to return to duty on the first workday following the expiration of approved leave.  I understand that I must notify my supervisor at least one week before this leave request expires if I am unable to return. I understand I must inform my supervisor of the reasons why I am unable to return, supply documentation if required and the new expected return to work date.  I understand that if I fail to return or communicate a new expected return date, I may be placed in an Absence Without Official Leave (AWOL) status. I understand that being placed in an AWOL status will subject me to discipline under Chapter 16 as it relates to attendance-related offenses.  I understand that if I fail to pay my benefit obligations, the total will be recoverable by the District from me, or my estate, in accordance with all applicable rules and regulations.  I read and understand the information provided above.  I elect to:  **Continue my currently elected health, life, dental, and vision benefits coverage**  I choose to:  Submit a lump sum  Incur a debt  **Terminate coverage** | |
| **Sign** | **Date** |

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| **SUPERVISOR APPROVAL** | |
| APPROVED  DISAPPROVED | |
| **Sign** | **Date** |

|  |  |
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| **AGENCY HEAD OR DESIGNEE APPROVAL** | |
| APPROVED  DISAPPROVED | |
| **Sign** | **Date** |

*Check here if a medical certificate from your physician is attached to the DCSF 1199 form. A medical certificate must be*

*included if your request is for medical reasons.*

**Distribution: Original** – Employing Agency; **Copy** – Employee; **Copy** – OPF; **Copy** – OPRS; **Copy** – DCHR Benefits