University of Colorado
Boulder | Colorado Springs | Denver | Anschutz Medical Campus
EMPLOYEE SERVICES

1800 Grant Street, Suite 400
400 UCA
Denver, CO 80203

t 303 860 4200
f 303 860 4299
1 855 216 7740 (toll free)
benefits@cu.edu

Leave Without Pay (LWOP) Form - Benefits Authorization

Classified Staff

INSTRUCTIONS

1. Review the Leave of Absence Fact Sheet – LOA Fact-Sheet
2. Complete the entire form, sign and date
3. Return the form to Employee Services (ES) by the required deadline
4. Do not use this form if your leave will be greater than 12 months; contact a Benefit counselor for information

EMPLOYEE INFORMATION

____

Name (Last) (First) (Middle Initial) HRMS Employee ID Number

____

Home Telephone Campus Department Supervisor Name and Phone Number

☐ Family Medical Leave Act (FMLA) LWOP from ________________ to ________________ or Unknown
mm/ dd / yyyy mm/ dd / yyyy

☐ University approved LWOP from ________________ to ________________ or Unknown
mm/ dd / yyyy mm/ dd / yyyy

☐ Military LWOP from ________________ to ________________ or Unknown
mm/ dd / yyyy mm/ dd / yyyy

BENEFIT OPTIONS

You may elect to continue or suspend some or all of your currently enrolled benefit plans. If you continue or suspend your benefits, all your enrolled eligible dependents will follow your election. Suspended coverage begins the last day of the month following your effective date of approved LWOP. If you want coverage to end on the first day of month of your effective date of approved LWOP, ES must receive all the necessary forms and documentation by the 10th of the month in which your LWOP is effective. Late requests will not be accepted.

Continue	Suspend	Not Enrolled	
☐	☐	☐	Medical
☐	☐	☐	Dental
☐	☐	☐	Optional Life – If suspended, may require approval from insurance company to reinstate previous coverage amount(s)
☐	☐	☐	Voluntary Accidental Death and Dismemberment (AD&D)
☐	☐	☐	Long Term Disability (LTD) – If suspended, may require approval from insurance company for reinstatement

Flexible Spending Accounts, Short-Term and Long-Term Disability: Review the Leave of Absence Fact Sheet for important information.

Retirement Contributions: Contributions are based on a percentage of salary. While on LWOP, contributions will cease; however, contributions will continue once you return to work in a benefits-eligible position.

PERA Participants: You must submit a PERA Leave Without Pay form to PERA within 90 days of the beginning date of your leave.

Military Participants: Review the Leave of Absence Fact Sheet for important information.

PREMIUM PAYMENTS

If you elect to continue your coverage while on LWOP, you will receive a monthly billing statement detailing the monthly cost of your benefit plans. Premium payments are due by the first of the month. Failure to pay premiums by the established due date will result in termination of coverage. Any remaining balance owed will be sent to the State of Colorado collection office.

RETURN FROM LEAVE WITHOUT PAY

When you return from LWOP, you must contact ES within 31 days of your return date. If you suspend your enrollment, you must submit a new Enrollment/Change form. Your effective date of coverage will be the date your return from LWOP if you return on the first day of the month. If you return on any other day of the month, your coverage will be effective the first of the month following the date you return from leave. If you do not submit a form within the required deadline, you will not be eligible to make changes until the next annual open enrollment.

AUTHORIZATION and SIGNATURE

I certify that by completing, signing, and returning this form, I agree to abide by the eligibility, enrollment, and election procedures for my University of Colorado benefits as outlined in this form, the Benefits Guide and online at www.cu.edu/es

I certify that I have been given the opportunity to continue or suspend group benefits insurance as offered by and through the University of Colorado.

I understand that I cannot change certain elections until the next open enrollment period unless I have a life event that qualifies as qualifying life event according to applicable federal and/or state laws or the master plan document.

I agree to utilize the appeal procedure(s) established by the carrier(s) for resolving claims disputes. Depending on the conditions set forth by the carrier, this agreement may require binding arbitration instead of a court trial for dispute resolution.

I acknowledge that carriers may release certain information about me and/or my dependent(s) when required under federal or state law, or pursuant to legal process, and may release and obtain medical information to or from other carriers, providers, and public agencies for the purpose of providing health care services, to facilitate payment for these services, and to conduct related administrative operations.

I hereby authorize the University of Colorado to bill me directly for any necessary premiums.

Employee's Signature _____ Date _____

How to Return Your Form

By Mail	**By Fax**	**In Person**
Make a copy for your records and send the original to: University of Colorado EMPLOYEE SERVICES 1800 Grant Street, Suite 400 Denver, CO 80203	303-860-4299 Keep a copy of the fax transmission report with your form for your records.	Bring your completed original form and a copy for your records to ES. The receptionist will date stamp both your original form and your copy. ES will keep the original.

FOR ES OFFICE USE ONLY

Date Processes:	Processed By:	Eligibility Date:	Benefit Rcd #:	HRMS updated to reflect LWOP: