# ASU LEAVE DESIGNATION NOTICE FOR FAMILY MEMBER HEALTH (NON-FMLA)

DATE: _____ Employee 10-digit ID: _____

TO:

_____

FROM: _____ _____

College or Department Name College or Department Number

Dear _____,

We have reviewed your request for leave and any supporting documentation that you have provided. We received your most recent information on _____ and determined:

☐ **Your request for leave has been approved. Begin date _____ through _____.**

- ☐ Extended Leave of Absence (staff)
- ☐ Health Related Leave with Pay (faculty/sick)
- ☐ Leave of Absence without Pay (faculty)

- The leave policy requires that you notify us as soon as practicable if dates of scheduled leave change or are extended or were initially unknown.

- If available, you may use paid sick, compensatory, and/or vacation hours to remain in a paid status.

**Responsibilities**

☐ You will be required to provide ASU with a re-certification from your family member's treating health care provider using the enclosed form once every _____ days or _____ weeks or _____ months.

**Benefits**

- While on leave, you may choose to continue your health benefits:
  During paid leave: The employee portion of the premiums will be deducted from your check as usual.
  During unpaid leave: You will be billed for both the employee and ASU portions of premiums.

  When you are billed, you have a minimum 30-day grace period in which to make payment. If payment is not made timely, your benefits will be cancelled 15 calendar days after the date of your Notice of Cancellation, retroactive to the last day of the pay period for which coverage had been paid.

- If you have the Health Care or Limited Health Care Flexible Spending Accounts (FSA), it may be continued while on a leave without pay by making payments directly to ASU on an after-tax basis. By doing this, you will have access to your account. Please contact HR to make arrangements.

  A Dependent Care FSA (also known as Child/Adult Day Care FSA) cannot be continued while you are in an unpaid status.

Within **31 calendar days** of returning to work, you must complete the ***Benefits Enrollment/Change Form*** to re-enroll in the medical and/or dependent accounts; otherwise this benefit will cease for the remainder of the calendar year.

- If you go to an unpaid status during your leave, it is a qualified event that allows you to make changes to your benefit plans. You have **31 calendar days** from the event date to submit benefits changes by completing the ***Benefits Enrollment/Change Form*** located in the HR Forms section of the Human Resources Web site. Please contact Employee Services at 480.965.2701 or Faculty Services at 480.727.9900 if you have questions.

☐ **Additional information is needed to determine if your leave request can be approved:**

☐ The documentation you have provided is not complete and sufficient to determine whether you qualify for a leave. You must provide the following information no later than _____, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied_____

_____

_____

☐ We are exercising our right to have you obtain a second or third opinion medical documentation at our expense, and we will provide further details at a later time.

☐ **Your leave of absence has been denied.**

If you have any questions, contact your department leaves representative _____ at (____) _____.

Enclosures:
☐ Benefits Enrollment/Change Form
☐ _____
☐ _____