TEMPLATE FOR UNPAID LEAVE OF ABSENCE
DATE

Dear (Department Chair's Name),

I am hereby requesting to take an unpaid leave of absence for (List Semesters if 9-month faculty or beginning and end dates if 12-month faculty). I understand that an unpaid leave of absence may not be granted for a period of more than 12 months. I also understand that if I am a 12-month bargaining-unit member that I must exhaust my vacation bank prior to beginning the unpaid leave of absence.

Statement of Reasons (Personal or Professional) for Requesting the Leave of Absence Without Pay:

Pursuant to Article XIII.A.1.e of the Collective Bargaining Agreement between Wayne State University and the AAUP-AFT:

> "a member of the bargaining unit may exercise his/her option (in writing) for continuance of medical and life insurance coverage at the full group rate cost, and without University subsidy, for the period of the leave, not to exceed a maximum of two years. For those individuals who are eligible for the University long-term disability insurance coverage and who are engaged in full-time study for an advanced degree, or active work in the field of education or research (such as a Fulbright, foundation grant, or governmental project), long-term disability insurance coverage shall be extended for the period of the leave, not to exceed two years."

If you wish to exercise this option, you should contact Total Wellness and Compensation. If you do not contact Total Wellness and Compensation, your benefits will discontinue.

I acknowledge that my benefits will discontinue unless I elect to take the option as indicated above and submit in writing to the Wayne State University Total Wellness and Compensation department my decision to pay my medical and/or life insurance at the full group rate cost, and without University subsidy, for the period of the unpaid leave of absence.

_____

Requestor's signature Print Name

I concur with this request for an unpaid leave of absence:

_____ _____

Department Chair Date Dean Date

_____

Barbara Price
Associate Vice President for Academic Personnel

c: Personnel File

WAYNE STATE UNIVERSITY

Leave of Absence Benefit Continuation/Application Form

Applicant Information (Please Type or Print):

Applicant Name: Last, First, MI | Soc. Sec. # | Birth Date

Address | City | State | Zip Code | Telephone No. (Include Area Code)

Send Bill To: (If Mailing Address Is Different From Above) | City | State | Zip Code | Telephone No. (Include Area Code)

Name of WSU Employee (If NOT Applicant)

☑ **Benefits You Wish To Continue/Apply For:**

- ❑ Blue Cross & Blue Shield
- ❑ Community Blue
- ❑ Blue Care Network
- ❑ DMC Care
- ❑ Health Alliance Plan
- ❑ Delta Dental
- ❑ Hartford Life Insurance

List All Family Members To Be Covered (not including yourself):

Name: Last | First | M.I. | Sex(M/F) | Birthdate

Spouse:

Child(ren):

I understand and agree to pay the required premiums for this coverage. I understand that failure to make prompt payments may result in the cancellation of this coverage.

I agree to cancel this coverage by writing to **Total Compensation & Wellness, Wayne State University, 5700 Cass Avenue, Suite 3638, Detroit, Michigan 48202**. I understand that if I do not provide written notice to cancel this coverage that I will be required to reimburse the University for premiums remitted to the insurance carrier on my behalf.

I hereby authorize Wayne State University (WSU) to collect the sum due from any amounts due to me by WSU including, but not limited to, compensation in the form of salary and/or wages for personal service. More specifically, in reference to deductions from salary and/or wages, I consent to and authorize WSU to make deductions from successive salary/or wage payments up to the maximum amount allowed by union contract or university policy, until the entire amount of my obligation has been satisfied.
I understand that if this is not possible, WSU will pursue all legal means of collection.

Applicant Signature_____ Date_____