HELPSIDE

NON-MEDICAL LEAVE OF ABSENCE APPLICATION

This request for non-medical leave will be denied if this form is not completed and submitted at least seven days in advance of the commencement of the leave.

Company Name	Employee Name	Social Security Number
Date Leave Begins	Anticipated Return Date	**Internal Use**: (Last Date of Eligible Leave)
Reason for Leave		

Employer –read and sign:

The above-named employee will be placed on an approved long-term (in excess of 30 days) non-medical leave as of the date indicated above.

It is agreed that we, the work site employer, will continue to maintain health, dental and vision insurance benefits for the duration of the leave. Non-medical leave may not exceed 90 days. We agree to pay 100% of the applicable health, dental, and vision insurance premiums as billed by Helpside for the duration of the leave. We also agree to pay per paycheck service fees as billed by Helpside. Furthermore, it is the responsibility of the worksite employer to notify Helpside when the employee returns from this non-medical leave of absence.

We expect that the employee will return to the same position that was held previous to the beginning of the leave. However, we do not make a promise or guarantee that the employee will be assigned to the same position, or that a position will be available at the end of the non-medical leave. This is not a contract for employment or promise of employment for a definite period of time. This agreement to continue benefit coverage does not alter the employee's status as an at-will employee.

We understand that if the employee fails to return to full-time status during, or upon the expiration of, the 90-day maximum leave period that benefit coverage will be terminated and the employee will be required to re-qualify for insurance by submitting a new application(s) and be subject to the standard waiting period for benefit coverage.

Work Site Employer's Signature: _____

Employee – read and sign:

I understand and agree that this request for non-medical leave of absence does not constitute a contract for, or a guarantee of future employment. If I do not return to full-time status during, or upon the expiration of, the 90-day maximum leave period I may or may not be able to continue my insurance coverage through cobra. Cobra will be offered only if my work site employer is required by law to offer it. I understand that if I do return to full-time employment with this work site employer that I am not guaranteed to be assigned to the same position or receive the same pay I had before the non-medical leave. I understand and agree that I will remain at all times an at will employee. I understand that if I decide not to return to full-time status prior to the end of my leave or if I accept employment elsewhere I must inform my work site employer and I promise to do so. Further, I promise to repay any insurance premiums that are paid on my behalf if I decide to accept employment elsewhere or if I decide not to return to full-time status for any reason. If my employer fails to pay my portion of the premium while on leave, I understand that my coverage may be canceled at any time prior to the expiration of my leave. Any falsification of information regarding this leave of absence may result in termination of coverage effective the last day of the month following the first day of leave.

Employee Signature _____ Date _____

☐ Approved

Helpside Authorization _____ Date _____ ☐ Denied