HONORHEALTH™

Staffing Leave Program Request Form

Staff member name:	**Employee ID number:**
Address, phone and email during leave:	**Present status:** ☐ Full-time ☐ Part-time
Department name and number:	**Hours worked per pay period:**
Start date:	**Return to work date:**

At the time your leave becomes unpaid, you will be responsible to pay your portion of insurance premiums up until the time you return to work. This will include medical, dental, vision, voluntary life insurance and long-term disability buy-up (if applicable), accident, critical illness, long term care, and legal plan. You must use a minimal amount of Paid Time Off (PTO) to cover these premiums.

When your leave becomes unpaid, a letter will be mailed to the address above providing you with instructions on how to pay your premiums.

I have read and understand the explanations outlined in the Staffing Leave Program.

Staff Member Signature:_____ Date: _____

APPROVALS

Supervisor: _____ Date: _____

Manager: _____ Date: _____

Please return this form to:
Employee Benefits Department
Fax: 480-882-5802
Email: employee.benefits@honorhealth.com

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