Please complete this form and upload it to Workday prior to going on your Military service leave of absence.

**Employee Information**

|  |  |  |
| --- | --- | --- |
| Employee Full Name | Last 4 digits of SSN | Home Address |
|  |  |  |
| Agency Name | Division/Unit | Job Classification |
|  |  |  |
| Employment Status  (Full time or Part time) | Probation or Permanent Status | Pay Grade/Bi-weekly rate of pay |
|  |  |  |

This request for Military service leave of absence should be accompanied by official military orders and should be submitted 30 days in advance of the first day of leave, when possible. If military orders are not available within the first 30 days of leave, a verification notice may be sent to your Military Unit.

**Military Orders**

|  |  |  |  |
| --- | --- | --- | --- |
| Military Pay Grade/Rank | Branch of Service | | |
|  |  | | |
| Date Ordered to report to duty (per orders) | Date Departing State of Iowa employment (last day worked) | Period of Service (Per Orders)  From : To: | |
|  |  |  |  |
| Name of Military Unit | Name/Rank of  Commanding Officer or Sr. NCO | Military Unit Address | |
|  |  |  | |

**Paid and Unpaid Leave**

❑ I understand that I am entitled to 30 workdays of military time off with pay. If some military time off with pay has already been paid within this calendar year, I am entitled to the remaining balance. The 30 days of military with pay time must be exhausted prior to utilizing other paid time off. While on military service leave of absence, I am entitled to an additional 30 work days of paid military time off at the start of each calendar year per Iowa Code 29A.28.

❑ I understand that I may elect to use or retain any vacation or compensatory time that was accrued prior to the military service leave of absence.

❑ I do not want to use any accrued vacation or compensatory time after my military time off with pay has been used and understand I will be placed on military service leave without pay.

❑ I want to use paid vacation or compensatory time after utilizing all my military time off with pay and understand that once this time is exhausted, I will be placed on military service leave without pay.

|  |  |  |  |
| --- | --- | --- | --- |
| Time Off Type | Current Balance (available prior to period of service) | Hours Requested | Order of Usage  (Immediately following Military Time Off w/pay) |
| Military Time Off w/Pay |  | NA | Used First |
| Vacation |  |  |  |
| Compensatory Time |  |  |  |

**Employee Benefits - Health and Dental**

❑ I understand coverage under the State of Iowa group medical and dental plans will continue for the period of time I continue to receive uninterrupted, military, compensatory or vacation pay. I am responsible for paying the employee’s share of the medical and dental insurance premiums while receiving paid time off through payroll deduction. Once my paid time off ends, and I begin leave without pay of more than 30 calendar days, the State share of my medical and dental insurance will end. The last month of State share eligibility will be the month in which my paid time off is exhausted. Once my eligibility for coverage under the State’s group ends, coverage cannot be reinstated until I return to employment.

❑ I understand I may maintain health and dental insurance coverage for my current covered dependents for up to 24 months. I will be required to pay 102 percent of the full premium through COBRA. If I choose to drop medical and dental insurance coverage for dependents during the period of military service leave, they are eligible for reinstatement of coverage upon my return to work with no waiting period.

❑ I do not want to continue medical and dental insurance for my current covered dependents.

❑ I want to continue medical and dental insurance for my current covered dependents and I will submit a COBRA application.

**Employee Benefits - Flexible Reimbursement Plans**

❑ I understand I may elect to continue with health flexible spending for the remainder of the calendar year and receive reimbursement for claims incurred for the remainder of the calendar year or I may not continue coverage but may still receive reimbursement for claims incurred through the end of the month in which I last contribute to the account.

❑ I do not want to continue my health flexible spending.

❑ I want to continue my health flexible spending.

❑ I will prepay the remaining contributions before going on unpaid leave.

❑ I will pay the regular monthly amounts with post tax dollars.

❑ I understand I may elect to continue with dependent care flexible spending for the remainder of the calendar year and receive reimbursement for claims incurred for the remainder of the calendar year. If I do not elect to continue, I may continue to use current funds in the account for eligible expenses incurred through the remainder of the year.

❑ I do not want to continue my dependent care flexible spending.

❑ I want to continue my dependent care flexible spending and will prepay the contributions before going on unpaid leave.

**Employee Benefits – Deferred Compensation**

❑ I understand upon my return from military service leave, I may request to repay missing contributions and receive the State’s matching contribution. If I wish to do this, I will contact the RIC Account Team at [ric@iowa.gov](mailto:ric@iowa.gov) in a timely manner after I have returned to work in order to exercise this right.

**Employee Benefits – Other Payroll Deductions**

❑ I understand all voluntary deductions such as credit union, One Gift and other vendors will cease during the period of leave without pay. I will plan to make personal payments with these vendors.

**Power of Attorney Information**

If you are completing this section, please submit a Power of Attorney to your Agency Human Resources representative

|  |  |  |
| --- | --- | --- |
| The person who has legal authority to act on your behalf regarding employment and benefit issues: | | |
| Name | Relationship | Address |
|  |  |  |
| Phone | Email address | |
|  |  | |

**Uniformed Services Employment and Reemployment Rights Act (USERRA):**

❑ I understand my rights, as stated under the Uniformed Services Employment and Reemployment Rights Act of 1994, enacted 10/13/1994, as amended.

❑ I do not intend to return to work; I will submit a resignation letter. I will obtain and complete a Military Resignation letter from my Agency Human Resources representative.

❑ I intend to return to work; I will submit a return to work notice, within the specified time limits following my period of service. Upon my return, I will provide a copy of my DD-214.

❑ If my leave has been extended, I will submit a new Military Service Leave of Absence Request Form along with updated military orders.

**Signatures**

|  |  |  |
| --- | --- | --- |
| Employee Signature | | Date |
|  | |  |
| Employer Representative (type or print) | Employer Representative Title (type or Print | |
|  |  | |
| Employer Representative Signature | | Date |
|  | |  |