MILITARY LEAVE OF ABSENCE REQUEST FORM (EXCEED 30 DAYS)

In addition to this form, please report your Military Leave of Absence to the Reed Group.

Phone: 844-507-5393 (toll free). Answered 8:00 a.m. to 8:00 p.m. Central Time, Monday through Friday
Fax: 720-456-4790
Online Portal: StateofIowa.LeavePro.com (self service)

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 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 leave with pay. If some military leave with pay has already been paid within this calendar year, I am entitled to the remaining balance. These military leave with pay hours will be exhausted before utilizing other paid leave. While on military leave of absence, I am entitled to an additional 30 work days of paid military leave 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 leave of absence.

- ❑ I do not want to use any accrued vacation or compensatory time after my military leave with pay has been used and understand I will be placed on military leave without pay.
- ❑ I want to use paid vacation or compensatory time after utilizing all my military leave with pay and understand that once this time is exhausted, I will be placed on military leave without pay.

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Leave Type	Current Leave Balance (available prior to period of service)	Hours Requested	Order of Usage (Immediately following Military leave w/pay)
Military Leave w/Pay			Used First
Vacation			
Compensatory Time			
Military Leave w/out Pay			

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 leave through payroll deduction. Once my paid leave 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 leave 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 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 received 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 leave, I may request to repay missing contributions and receive the State's matching contribution. If I wish to do this, I will contact my Agency Human Resources representative in a timely manner after I have returned to exercise this right.

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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 make arrangements to make personal payments with these vendors.

Contact Information

(If you are completing this section, please submit a POA 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 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

A copy of this completed document must be provided to:

Employee
Employee Personnel File
Dept. of Administrative Services – Human Resources Enterprise – Group Benefits