Evanston Campus: Human Resources 720 University Place Evanston, IL 60208-1145 Phone (847) 491-7513 FAX (847) 467-4284	Northwestern University **Leave of Absence Request Form** **Repatriation Leave**	**Chicago Campus Employees**: Human Resources, Abbott Hall 710 North Lake Shore Drive Chicago, IL 60611-3008 Phone (312) 503 – 0494 FAX (847) 467-4284

EMPLOYEE INFORMATON:

Name Last First M.I			Employee ID:
U.S. Address Street Apt. City State Zip code			
Job Title:	Department:		Campus:
Employment Status ☐ Biweekly ☐ Monthly	Date of Hire:	Campus Phone:	Home Phone:
Leave Start Date:		Leave End Date:	

ACKNOWLEDGEMENT:

I understand that this leave will be unpaid unless I chose to use accrued vacation and/or personal floating holiday time, and that this leave will not exceed a six month period. In order to continue employee benefits during leave, I must make arrangements with the Benefits Division for payment of any required employee premiums during any unpaid portion of my leave. I am aware that I will only be able to continue health, dental, and/or vision benefits for any unpaid portion of my leave. If I find employment (at Northwestern University or elsewhere) prior to the expiration of my Repatriation Leave, I understand that it is my responsibility to notify the Benefits Division.

Employee Signature:	Date:

APPROVAL:

Requests for leave of absence must be reviewed by the Department of Human Resources for authorization or denial.

HUMAN RESOURCES: The request for the leave of absence is: ☐ Approved Repatriation leave ☐ Denied, Reason: ____ If approved, first date of unpaid leave:_________________________	Name (Please Print) Title Signature Date

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BENEFIT ELECTIONS:

Medical Coverage ❑ Enroll ❑ Waive	**Choose Your Health Plan** ❑ Premier PPO (BCBS) ❑ Select PPO (BCBS) ❑ Value PPO (BCBS) ❑ HMO Illinois	**Dental Coverage** ❑ Enroll ❑ Waive	**Choose Your Dental Plan** ❑ First Commonwealth (FCW) ❑ Dearborn National	**Vision Coverage** ❑ Enroll ❑ Waive
Provider (HMOIL: 3-digit Grp #)		Provider (FCW: 6-digit Location)		

* If I chose to waive health care coverage, I acknowledge that Northwestern University offers employer sponsored health care plan coverage and requires all benefits eligible faculty and staff to elect or waive such coverage. I do not wish University sponsored coverage. I acknowledge my full responsibility for medical/hospitalization and outpatient expenses of any kind when incurred and release and discharge Northwestern University, its employees and agents from any obligations I may incur as a result of an illness or injury.

Signature **Date**

ADD DEPENDENTS

Only complete the following section for dependents you want covered under your insurance.

Relationship Codes: S=Spouse **NA**=Partner **C**=Child **FC**=Foster Child **RC**=Recognized Child **SC**=Stepchild **AC**=Adult Child (disabled over 26) **NC**=Partner's Child

Last Name (if different from employee), First Name MI	❑ Male ❑ Female	Date of Birth	Relationship Code:	Social Security Number
Medical Coverage ❑ Enroll ❑ Waive Provider (HMOIL: 3-digit Grp #)	**Dental Coverage** ❑ Enroll ❑ Waive Provider (FCW: 6-digit Location)			**Vision Coverage** ❑ Enroll ❑ Waive

Last Name (if different from employee), First Name MI	❑ Male ❑ Female	Date of Birth	Relationship Code:	Social Security Number
Medical Coverage ❑ Enroll ❑ Waive Provider (HMOIL: 3-digit Grp #)	**Dental Coverage** ❑ Enroll ❑ Waive Provider (FCW: 6-digit Location)			**Vision Coverage** ❑ Enroll ❑ Waive

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