



# University of Alaska

**Family Medical Leave Without Pay (FMLWOP)**  
**Sick Leave Without Pay (SLWOP)**  
**Leave of Absence Without Pay (LOAWOP)**

MAU/Major Administrative Unit (circle one)				Department
UAA	UAF	UAS	SW	
Last Name		First	M.	
Employee ID			Work Phone	

Contract Term:

- 9, 10, 11 month
- 12 month

Annual Salary \$ \_\_\_\_\_

**Notice:** Per Board of Regents Policy and University Regulation, you must exhaust annual, sick, and family medical leave, as appropriate, before being eligible for SLWOP. For both SLWOP and LOAWOP, you must pay the premiums to continue benefits. SLWOP constitutes a life event and allows you to enroll, drop, or change your supplemental coverage, or add or delete dependents within 30 days by completing an Employee Selected Benefits and Deductions, Dependent Enrollment, or Beneficiary Designation (for AD&D and Supplemental Life) form.

**Family Medical Leave Without Pay (attach the FML Request form)**

Approved dates: From \_\_\_\_\_ to \_\_\_\_\_ First Payment Due: \_\_\_\_\_

Expected date Sick/Annual leave will be exhausted: \_\_\_\_\_

**Sick Leave Without Pay**

Approved dates: From \_\_\_\_\_ to \_\_\_\_\_ First Payment Due: \_\_\_\_\_

Date Sick/Annual/FM leave exhausted: \_\_\_\_\_ Reason for SLWOP: \_\_\_\_\_

**Leave of Absence Without Pay**

Approved dates: From \_\_\_\_\_ to \_\_\_\_\_ First Payment Due: \_\_\_\_\_

Reason for LOAWOP: \_\_\_\_\_

Please check the appropriate box. Some months have three pay periods.

**Bi-Weekly**

**Monthly**

**Employee Health Care** (only available if on FMLWOP)

- Yes, I will continue my coverage by paying this bi-weekly premium \$ \_\_\_\_\_ \$ \_\_\_\_\_
- No, I do not wish to continue my coverage.

**Dependent Health Care** (only available if on FMLWOP)

- Yes, I will continue my coverage by paying this bi-weekly premium \$ \_\_\_\_\_ \$ \_\_\_\_\_
- No, I do not wish to continue my coverage.

**Supplemental Life**

- Yes, I will continue my coverage by paying this bi-weekly premium \$ \_\_\_\_\_ \$ \_\_\_\_\_
- No, I do not wish to continue my coverage.

**Accidental Death & Dismemberment**

- Yes, I will continue my coverage by paying this bi-weekly premium \$ \_\_\_\_\_ \$ \_\_\_\_\_
- No, I do not wish to continue my coverage.

**Basic Life Insurance** (provided at no cost while on FMLWOP)

- Yes, I will continue my coverage by paying this monthly premium \$ \_\_\_\_\_
- No, I do not wish to continue my coverage.

**Long Term Disability** (provided at no cost while on FMLWOP)

- Yes, I will continue my coverage by paying this monthly premium \$ \_\_\_\_\_
- No, I do not wish to continue my coverage.

**TOTAL Monthly Insurance Premium Due** \$ \_\_\_\_\_

I have been advised of my benefit options and have received information regarding continuation of health plan coverage (COBRA).

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Personnel/Benefits: \_\_\_\_\_ Date: \_\_\_\_\_

Please make checks payable to the University of Alaska.  
Mail to: Statewide Human Resources, 212 Butrovich Bldg., P.O. Box 755140, Fairbanks, AK 99775-5140.

Entered by: \_\_\_\_\_ Date: \_\_\_\_\_