



**ELECTION TO CONTINUE DIRECT PAY
FOR EMPLOYEES ON LEAVE OF ABSENCE**
HUMAN RESOURCES

Employee Support Services ■ One Washington Square ■ San José, CA 95192-0046

408-924-2250 ■ 408-924-1701 (fax)

- Instructions:**
- Complete this request and return to Human Resources, Employee Support Services, UPD, 0046. Upon receipt, the proper forms will be sent to you.
 - Please print or type in ink.

EMPLOYEE INFORMATION	
Employee Name:	Employee ID Number:
Department/College Name:	
Leave of Absence Dates: From: _____ To: _____	Campus Phone Number:
Mailing Address While on Leave:	Home Phone Number: ()
	Phone Number While on Leave: ()
Alternate Contact Name and Address:	Alternate Contact Phone: ()

ELECTION TO CONTINUE DIRECT PAY OR DECLINE CONTINUATION (premium rates on page 2)				
Enroll	Decline	Type of Coverage	Plan Name	HR Use Only
<input type="checkbox"/>	<input type="checkbox"/>	Medical		
<input type="checkbox"/>	<input type="checkbox"/>	Dental		
<input type="checkbox"/>	<input type="checkbox"/>	Vision		
<p>Continue Coverage (Enroll): I understand that my request to continue coverage must be received at the address provided below within 30 days from the beginning of my leave. I also understand that I am fully responsible for the premium payment. Failure to pay the premium in a timely manner will result in the termination of my coverage.</p> <p>Decline Coverage: I understand that I will not be eligible to continue or re-start my coverage if the request to do so is received at the address below more than 30 days after the start of my leave of absence.</p>				
Signature _____			Date _____	

EMPLOYEE SUPPORT SERVICE USE ONLY
Benefit Services Representative: _____
Direct Pay Effective Date: _____