January 6, 2011

Name
Address
City/State/Zip

Dear

I have been notified by your department that you will be in leave without pay (LWOP) status. Please be aware that your active benefit coverage will go through the end of the month in which you last worked. Please read the enclosed document *Life Events Impacting Benefits ~ Leave Without Pay* containing information related to your benefits while on a LWOP status.

Enclosed is a personalized Premium Election Form indicating the cost of your premiums should you elect to maintain benefit coverage while in this LWOP status.

If circumstances change related to the dates of your leave, please communicate this information with your Department Business Office or Supervisor immediately as this can impact your employment status.

Please contact my office at 979-458-7693 or teeshr@tamu.edu if you have any quesitons related to your benefits while on leave.

Please return forms and/or payment to:
TEES Personnel Services
c/o Sarah Tobola
MS-3467
College Station, TX 77843-3467

Sincerely,

Sarah Tobola, CEBS, PHR
Sr. Employee Benefits Representative

Enclosures:

- Personalized Premium Election Form
- Life Events Impacting Benefits ~ Leave Without Pay

Premium Election Form

Name: _____ UIN: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____ Home Phone: _____

Leave Start Date _____ Expected Return Date: _____

I have read and understand the enclosed *Life Events Impacting Benefits ~ Leave Without Pay* document. Select with an "X" any insurance coverage you wish to retain while on leave. The monthly premium cost for your current coverage is indicated to the right of the applicable insurance.

Select	Insurance Coverage	Employee Cost
_____	Basic Life	_____
_____	Health	_____
_____	Dental	_____
_____	Vision	_____
_____	Optional Life	_____
_____	Dependent Life	_____
_____	Accidental Death/Dismemberment	_____
_____	Long-Term Disability	_____
_____	Long-Term Care - Employee	_____
_____	Long-Term Care - Spouse	_____
	TOTAL MONTHLY COST	_____

Payment Option:

- ☐ Monthly Bank Draft – **ONLY** If on leave for **MORE** than 3 months (Complete Authorization below)
- ☐ Monthly Billing – ***NO CASH PAYMENTS ACCEPTED - ONLY A CHECK OR MONEY ORDER WILL BE ACCEPTED (check payable to TEES)***
- ☐ Advance Payment ___Quarterly ___Semi-Annually ___ Annually

The due date of my initial premium is _____

Employee's Signature:_____ **Date**:_____

BANK DRAFT AUTHORIZATION

I hereby authorize the Texas A&M University System to draft my bank account designated below for the amount of my monthly insurance premium. This payment is for group insurance carried by the System for which I have voluntarily subscribed. I further agree that should I desire to terminate or change said coverage, I will notify the Texas A&M University System and the below named bank in writing at least thirty days prior to the effective termination date. I understand this authorization remains in effect until terminated by me. I also understand that Texas A&M University System will notify me in writing if the monthly premium amount changes.

Bank Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Area Code: _____ Business Phone: _____

*Bank Routing # _____ Your Account No.: _____

Account Type: ☐ Checking ☐ Savings

***Contact your bank for this 9-digit number if unknown**

☞ ***ATTACH A VOIDED CHECK TO ACTIVATE***