Return From Leave of Absence - Disability Form

Employer Name: _____ Location ID No.: _____

Name of Employee: _____ SSN: _____

Please Check (✓) One: Returning from a ❒ Personal ❒ Medical
❒ Family Medical Leave of Absence (FMLA)

Return to Work Date: _____ No. of Hours Working Per Week: _____ Annual Salary: $ _____

Signature of Employer: _____ Date Signed: _____

Please be advised that if the employee waived medical/dental/vision coverage (optional benefits) while on a leave of absence or disabled, and wants to reapply for optional benefits, the employee will be required to complete a Late Entrant/Prior Waiver Form. Benefits will not be effective until the first of the month following a six month deferral period. The six month deferral period begins on the day we receive the form. Once enrolled, there will be a twelve month preexisting condition period (less prior creditable coverage if applicable) and deferred dental.

Christian Brothers Employee Benefit Services
1205 Windham Parkway, Romeoville, IL 60446-1679

Revision Date: 7/25/99