City of Gardner
Department of Personnel
95 Pleasant Street
Gardner, MA 01440
(978) 630-4001 • Fax (978) 630-4025

MILITARY LEAVE FORM

Date: _____

Employee Name: _____
(First, Middle Initial, Last)

Department: _____ Employee #: _____

Begin Leave: _____/_____/_____ Return from Leave: _____/_____/_____

Employee will use accumulated personal, compensatory and vacation time during requested leave:

☐ Yes ☐ No

Employee is currently covered by the City of Gardner's health and/or insurance benefits:

☐Yes ☐ No

If yes, you may elect to continue to maintain your health and/or dental insurance benefits with the City of Gardner. Do you intend to continue your health insurance benefits during the term of your military leave?

☐Yes ☐ No

If yes, you must continue to pay your portion of the health and/or dental insurance premiums in the amount of $_____ (health) and/or $_____ (dental). The following arrangements have been made:

☐ I have elected to use accumulated personal, compensatory and vacation time during the term of my military leave. My health and/or dental insurance premiums will continue to be deducted from my weekly earnings, until such time as I have exhausted my available accumulated personal, compensatory and vacation time.

and/or

☐ I will forward premium payments made payable to the City of Gardner, 95 Pleasant Street, Gardner, MA 01440 on the 10th day of each month.

You have a minimum 30-day grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during your military leave and recover these payments from you upon your return to work. If you do not return to work following your military leave for a reason other than (1) the continuation of your military leave; (2) onset of a serious health condition; or (3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your military leave

_____ _____
Employee Signature Date

_____ _____
Department Head Signature Date

_____ _____
City Auditor Signature Date

_____ _____
Personnel Director Signature Date