



Personnel Department
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 Dothan, AL 36302
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Military Leave Form

Name: _____

Job Classification: _____

Department/Division: _____

Date(s) of Leave: _____

This form is to be completed **as soon as possible prior to departure** for uniformed service when it is feasible to do so and **provided to your supervisor and payroll clerk** for submission to Personnel. **Please attach orders/schedule if available.**

SECTION I – Military Leave Type

Indicate whether your military leave is for drill, training, deployment, Governor issued or other by checking the appropriate box:

Drill	Training
Deployment	Governor of Alabama Mandate
Other _____	

SECTION II: Use of Leave Balances

Per Section 31-2-13 of the Code of Alabama states:

... "no person granted a leave of absence with pay shall be paid for more than 168 working hours per calendar year, and those persons shall be entitled, in addition thereto, to be paid for no more than 168 working hours at any one time while called by the Governor to duty in the active service of the state."

Please indicate your selection(s) below:

- I elect to utilize my Military Leave provide by the City, as indicated in the above, during my military leave of absence.
- I elect to utilize my accrual balances, as indicated in the below, during my military leave of absence. **Please note, sick leave may not be used for military leave.**

Select use and how many hours per pay period:

<input type="checkbox"/> Holiday	_____	Hours per pay period
<input type="checkbox"/> Vacation	_____	Hours per pay period
<input type="checkbox"/> Other	_____	Hours per pay period

- I **do not** wish to use my Holiday and/or Vacation accrual balances while on military leave.

Note: By checking this box and not using leave balances, you acknowledge that you will be in an unpaid status and may be responsible for the employee share of the insurance premium costs and will be billed. You must fill out the Military Leave – Insurance Options form in Personnel prior to beginning military leave

Name: _____ Department/Division: _____

Section III: Designated Contact Person

Deployment/Extended Training

If you would like to designate a contact person to help coordinate benefits, discuss related information, or receive employment information during your military leave, complete this section. This is not a beneficiary designation.

I, the undersigned, authorize City of Dothan to discuss employment related information, including personnel records, leave of absence and benefits, with _____
(the person named below). Therefore, I knowingly and voluntarily exonerate, release and discharge the City of Dothan from any liability, claim of damages, now or in the future, whether in law or in equity, on behalf of myself, my agents, heirs or assigns, for granting disclosure of confidential personnel records.

I do not wish to designate a contact person.

Designated Contact Person Information:

First and Last Name: _____
Relationship: _____
Address: _____
Phone #: _____
Email Address: _____

Please provide the below information if not included on orders/schedule:

Unit POC: _____
Unit/Location: _____
Phone #: _____
Email address: _____

Section IV: Acknowledgements

*I certify that the type of military leave I am embarking on has been correctly indicated, to the best of my knowledge. I further acknowledge that if I am in an unpaid status, I will be responsible for paying 100% of the employee share of monthly premiums for my benefit coverage, unless I choose to discontinue them. **I will be responsible for providing appropriate documentation (ie. DD-214, duty orders, etc.) to the City of Dothan upon my return if my leave for service was more than 30 days.***

Employee Signature

Date

Name: _____ Department/Division: _____

Military Leave – Insurance Options

While on Military Leave, employees have the option to cancel insurance coverage, continue all or part of the coverage, or cancel the employee's coverage but keep health/dental coverage for dependent(s). Please select the option that best suits your needs while on military leave:

Cancel all coverage and be reinstated the first day I return to active employment.

Continue coverage as selected below:

Health/Dental

Employee Only

Employee + Dependent(s)

Dependent(s) Only**

Vision

Employee Only

Employee + Dependent(s)

Supplemental Insurance*

Employee Only

Employee + Dependent(s)

I understand I will be responsible for paying the premiums of the coverage selected above. I have the option to pay the missed premiums in full when I return if I select employee only coverage, or I can have the premiums billed monthly to my Designated Contact Person. In order for my dependent(s) coverage to be continuous while I am on leave, the premiums due will be billed monthly to my Power of Attorney/Dependent and payment will be due as required on the statement of premiums due.

Pay missed premiums for employee only coverage in full when I return.

Pay premiums monthly with an invoice mailed to my Power of Attorney/Dependent.

Name _____

Address _____

Phone # _____

EMPLOYEE SIGNATURE

DATE

*Supplemental insurance includes Accident, Critical Illness, Hospital Indemnity, Short Term Disability, Long Term Disability, Term Life, and Whole Life.

**If Dependent(s) Only is selected, you will only be required to pay the difference of the selected coverage from single coverage.