

**LEAVE WITHOUT PAY (LWOP) CHECKLIST
(Personal Reasons Only-Over 30 days; NTE 1 Year)**

TECHNICIAN INFORMATION:

Last Name: _____ First Name: _____ Middle Name: _____
SSN: _____ Unit: _____ Pay Plan-Series-Grade: _____
Street Address: _____ APT # _____
City: _____ County: _____ State: _____ Zip: _____ + _____
Phone: (_____) _____
Email: _____

INITIAL ELECTIONS/ACKNOWLEDGEMENTS:

_____ I want to be placed in Leave Without Pay (LWOP) status starting on _____ (DATE)
_____ Are you invoking your FMLA rights? Circle **YES** or **NO** (If YES attach OPM 71 & FMLA paperwork)

FEDERAL EMPLOYEE HEALTH BENEFITS (FEHB):

_____ I do **NOT** have FEHB.
_____ I elect to **cancel** my FEHB. I must make my election through EBIS or through ABC-C.
_____ I elect to **terminate** my FEHB. My SF 2810 is attached with Effective Date: _____
_____ I elect to **retain** my FEHB and I choose one of the following ways to pay my premiums:
_____ I elect to incur a debt
_____ I elect to continue my FEHB and pay my bi-weekly premiums on a continuing basis during my absence; payments are made to DFAS Disbursing Center, P.O. Box 998019, Cleveland, OH, 44199-8019 (Payments should include members SSN and annotate LWOP FEHB).

FEDERAL EMPLOYEE DENTAL & VISION INSURANCE PROGRAM (FEDVIP):

_____ I have reviewed my LES and I do **NOT** have FEDVP.
_____ I understand my FEDVIP options and will contact the BENEFEDS Customer Service regarding my elections and options during a personal LWOP. [(877) 888-FEDS].

FLEXIBLE SPENDING ACCOUNTS:

_____ I have reviewed my LES and I do **NOT** have FSAFEDS.
_____ I understand that I must notify FSAFEDS immediately of the change in employment status. [(877) 372-3337].

FEDERAL LONG TERM CARE INSURANCE PROGRAM:

_____ I have reviewed my LES and I do **NOT** have FLTCIP
_____ I understand that I must notify FLTCIP immediately of the change in employment status. [(800) 582-3337].

FEDERAL EMPLOYEE'S GROUP LIFE INSURANCE (FEGLI):

_____ I do **NOT** have FEGLI.
_____ I elect to **discontinue** my FEGLI and am aware that I must make my election through?
_____ I elect to **continue** my FEGLI. I choose one of the following ways to pay my premiums:
_____ I elect to incur a debt
_____ I elect to continue my FEGLI and pay my bi-weekly premiums on a continuing basis during my absence; payments are made to DFAS Disbursing Center, P.O. Box 998019, Cleveland, OH, 44199-8019 (Payments should include members SSN and annotate LWOP FEGLI).

THRIFTS SAVINGS PLAN (TSP):

_____ I understand that I will be missing any agency matching while on LWOP (unless in a pay status and contributing).
_____ I have a TSP Loan **YES** or **NO** (Circle One). If yes, my TSP Form 41 is attached.

NATIONAL GUARD ASSOCIATION OF THE UNITED STATES (NGAUS) DISABILITY INSURANCE:

_____ I am **NOT** enrolled in NGAUS Disability and/or Term Life Insurance.
_____ I have attached an NG 76 for my enrollment in NGAUS Disability and/or Term Life Insurance.

OFFICE OF WORKER'S COMPENSATION PROGRAM (OWCP):

_____ I have an **OPEN / CLOSED** (Circle one) OWCP claim on file. Claim #: _____
_____ I do not have/don't know if I have an OWCP claim on file.

PLEASE READ AND INITIAL ALL STATEMENTS:

_____ I understand that any allotments established on my technician pay will be stopped while on LWOP and automatically restored upon returning to a paid technician status.
_____ I understand that if I have child support payments being taken from my technician pay that I must make other arrangements for payment.
_____ I understand that placement in LWOP status can affect my leave accruals, retirement eligibility date, and future within-grade increase due dates.
_____ I understand my elections.

(Technician Signature)

(Date)

FOR THE SUPERVISOR (initial/sign)

_____ I have reviewed and answered any questions related to my employees LWOP request. I understand it is my responsibility to stay in contact with our Human Resources Remote Designee during this employee's absence.

SUPERVISOR NAME: _____ **SUPERVISOR SIGNATURE:** _____