[Company Letterhead]

[DATE]

[EMPLOYEE NAME]

[EMPLOYEE ADDRESS]

Re: Personal Leave of Absence and Company-Sponsored Insurance Benefits

Dear [EMPLOYEE NAME]:

Thank you for letting us know that you will require a personal leave of absence due to extenuating circumstances related to COVID-19. We are pleased to inform you that the company has approved your request for personal leave.

**Duration of Leave**

We realize that at this time you are unsure of the amount of time that you will require away from work. We ask that you keep the lines of communication open with us regarding your return-to-work plans.

OR

We have approved your leave beginning on [DATE] and ending on [DATE].

**Pay During Leave**

Your leave of absence will be unpaid. If you have available accrued paid time off, you are welcome to use those benefits during this time. If you elect to use your paid leave, please submit a written request to use your paid leave benefits.

**Paid Time Off Benefits During Leave**

Sick leave, vacation time, seniority, and other benefits will not accrue during an unpaid leave of absence. Any paid holidays that occur during the leave of absence are not paid.

**Contact During Leave**

While you are on leave, we ask that you contact us [DESIRED FREQUENCY/DAY OF WEEK] to update your status. You may contact us via phone or email at [CONTACT INFORMATION]. If you fail to communicate as requested twice in a row, we will assume that you no longer wish to continue employment and we will proceed with the termination process.

**Job Restoration**

We will attempt to accommodate your needs as well as the needs of the company during this time. It is our hope that we will be able to accommodate your needs and return you to your previous position. However, if your absence creates an undue hardship on the company’s operations, we may consider a transfer or separation of employment. Your employment with our company is “at-will,” which means that either you or the company may terminate the relationship at any time.

While it is currently not our intention to separate your employment, if we must do so due to business necessity, you are encouraged to apply for an open position for which you are qualified once you are ready to return to work.

**Company-Sponsored Insurance Benefits**

Continuing your benefits during this time is optional. You are not required to elect to continue benefits during such periods. Should you wish to discontinue any of your benefits plans, notify us immediately so we may contact the insurance carrier(s).

If you wish to continue your benefits during this time, you will be required to remit payment for [your portion OR the entire amount] of the benefits premiums. As long as you continue to send in payments on time, the company will continue your company-sponsored insurance plans as long as the applicable carriers allow.

The costs of your current insurance plans are as follows:

|  |  |  |
| --- | --- | --- |
|  | Pay Period Cost | Monthly Cost |
| Medical Insurance | $ | $ |
| Dental Insurance | $ | $ |
| Vision Insurance | $ | $ |
| Life Insurance | $ | $ |
| Other: [list] | $ | $ |
| **Total** | $ | $ |

You will be required to make payments on a monthly basis to continue your current insurance benefits. Insurance payments are due on the first of the month for that month’s coverage. Your first payment will be due on [DATE (generally the first day of the leave)] and will be prorated to cover the following pay periods: [PAY PERIOD DATES].

If you would like to continue all of your current insurance plans, the amount of the first payment will be [$].

The monthly amount will be [AMOUNT] thereafter and will be due on the first day of each month. If you return to work in the middle of a month, we will prorate your final month of premiums at that time.

Your benefits payments should be mailed to:

[NAME]  
[STREET ADDRESS]  
[CITY, STATE ZIP]

The company reserves the right to discontinue your benefits coverage if you fail to remit payment in a timely manner. We will contact you first so that you are aware your insurance coverage is in jeopardy. In addition, if you become ineligible to participate in any benefit plans due to the carrier’s eligibility requirements, we will contact you and remove you from the plans.

Should your benefits terminate, you will be eligible to continue your benefit plans under COBRA or state continuation coverage. For example, if you inform the company of your intent not to return from leave, you will be eligible to continue your benefits under either federal COBRA or state continuation coverage, and you will receive a separate notice regarding your continuation rights and responsibilities.

If the company cancels your coverage due to lack of payment, you will have the right to restore your insurance coverage without condition once you return to work. While it is not our intention to do so, if the company opts to cover any of the employee portion of your insurance premiums while you are on leave, the company retains the right to deduct such premiums from your paycheck once you return to work.

It is important to us that you understand your rights and responsibilities during your personal leave. If you have any questions or concerns, please contact [NAME], whose contact information is listed below.

We wish you all the best during your leave and look forward to your return to work.

Sincerely,

[NAME]

[CONTACT INFORMATION]