

**FACULTY AND ACADEMIC LEAVE OF ABSENCE
BENEFIT INFORMATION FORM****Personal Data:**

Name: _____

Social Security #: _____

Department: _____

Rank/Title: _____

Status Data:

Leave of Absence Begin Date: _____

Leave of Absence End Date: _____

Compensation During LOA:

Salary Benefits are to be Based On: _____

Salary through U of C Payroll System: _____

Benefits Data:

Health Insurance (Y/N) Option _____

Dental Insurance (Y/N) Option _____

Group Life Insurance (Y/N) Option _____

Personal Accident Insurance (Y/N) Option _____

Long Term Disability Insurance (Y/N) Option _____

Terms and Conditions:

Department paying for the University's portion of benefits: (Y/N)

Comments:

Name, University address and phone number of Authorized Signer to whom we will forward Form 62, if applicable:

Please return this form and appropriate documentation to Benefits, 6054 S. Drexel Avenue, Chicago Illinois 60637