GOVERNMENT OF THE UNITED STATES VIRGIN ISLANDS

DIVISION OF PERSONNEL

"Doing the People's Business"

REQUEST FOR LEAVE WITHOUT PAY

SECTION A: (To be completed by Employee)

NAME: _____ EMPLOYEE NUMBER:_____

DEPT.:_____ POSITION: _____

L.W.O.P. BEGINNING DATE: _____ L.W.O.P. ENDING DATE:_____

REASON FOR REQUEST: _____

_____

SIGNATURE:_____ DATE:_____

NOTE: During periods of LWOP it is the responsibility of the employee to pay his/her portion of the Government Employees Group Health and Life Insurance. **The Department will be billed for the Government's matching portion.** When approved for LWOP, a payment schedule will be provided, upon contacting the Group Health Insurance Office at the Division of Personnel. Failure to comply with the due dates and premium amounts reflected on that schedule will result in immediate cancellation of the Group Health/Dental and Life Insurance Coverage.

SECTION B: (To be completed by Immediate Supervisor)

DATE REQUEST RECEIVED: _____ RECOMMENDED FOR APPROVAL: YES [ ] NO [ ]

JUSTIFICATION: _____

_____

SIGNATURE: _____ TITLE: _____ DATE: _____

SECTION B: (To be completed by Agency Head)

APPROVAL: YES [ ] NO [ ] JUSTIFICATION: _____

_____

SIGNATURE: _____ TITLE _____ DATE: _____

SECTION C: (To be completed by Departmental HR Officer)

DATE RECEIVED: _____ DATE ELECTRONIC NOPA PREPARED: _____

I, the undersigned officer hereby verify that a payment schedule was provided to the employee on _____.

SIGNATURE: _____ TITLE: _____ DATE: _____

SECTION D: (Division of Personnel Group Health Insurance Office)

RECEIVED BY: _____ TITLE: _____ DATE:_____

ENTERED INTO ERP SYSTEM: YES [ ] NO [ ] EMPLOYEE PROVIDED WITH PAYMENT LETTER YES [ ] NO [ ]