HEALTH ASSOCIATION NOVA SCOTIA

APPLICATION FOR CONTINUATION OF GROUP BENEFITS - RETIRED MEMBERS

RETE

ELIGIBILITY: Employee must have 10 years of continuous service and be in immediate receipt of a Nova Scotia Health Employees' Pension Plan (NSHEPP) or employer sponsored pension plan.

Last Name	First Name	Middle Initial	SIN

Employer Name	Union	Retirement Date (MM/DD/YYYY)	Date of Birth (MM/DD/YYYY)

Mailing Address	City	Province

Postal Code	E-Mail Address	Telephone Number

HEALTH COVERAGE

☐ I wish to continue coverage under the Health Association Nova Scotia **HEALTH PLAN.**

☐ Single Under age 65
☐ Family Under age 65
☐ Over/under age 65
☐ Single Over age 65
☐ Family Over age 65

☐ I wish to CANCEL my coverage under the **HEALTH PLAN** upon my retirement. I understand that I will not be eligible for retirement coverage at a later date.

☐ I wish to waive my coverage under the **HEALTH PLAN** upon my retirement because I am covered under my spouse's plan. I understand I will be eligible to enroll only in the event I lose this coverage and apply for coverage with 60 days of losing that coverage.

Name of the alternate insurer: _____

Identification Number: _____ Policy Number: _____

NEW / CHANGE DEPENDENT(S) INFORMATION

Action*	Relationship	Last Name	First Name	Initial	Sex	Date of Birth			Dependent Status**
						MM	DD	YY	
	Spouse	02 -							
	Child	03 -							
	Child	04 -							
	Child	05 -							

* D – Delete, A – Add, C – Change

** CH – Child, E – Student (college/university), S – Disabled

Please indicate any other dependent children on an additional application form. If the dependent child is between ages 21 and 26, you must provide proof that your child is attending an accredited educational institution on a full-time basis. If the child is disabled please see HANS for the appropriate forms.

Last Name	First Name	Middle Initial	SIN

GROUP LIFE INSURANCE COVERAGE

☐ I have elected to continue coverage on a reducing basis and am responsible for paying all premiums required to maintain coverage. I agree to pay the monthly premium (.30 per $1,000 of coverage) effective _____.
I am aware the monthly premium will reduce as my coverage reduces and that Health Association Nova Scotia will issue a certificate detailing the reduction process and the amount of insurance in effect.

☐ I have read the eligibility requirements to continue coverage under the Health Association Nova Scotia Retiree Life Insurance Plan (as stated above) and have opted to terminate coverage upon retirement**. I UNDERSTAND THAT THE TERMINATION OF MY LIFE INSURANCE COVERAGE IS NOT REVERSIBLE. I am aware that I do have the option to convert my coverage and/or my spousal coverage to a private plan as long as I do so within 31 days from my date of retirement.**

Beneficiary Designation for Group Life Insurance Coverage

Subject to applicable legislation, I hereby designate the following to receive any benefits payable from the plan checked above in the event of my death. I reserve the right to change my beneficiary designation. I understand that, if I do not designate a beneficiary, my estate will receive any benefits payable in the event of my death, in accordance with the laws of the area in which I reside. My employer and Health Association Nova Scotia assume no responsibility for the validity or effect of this designation. By completing a new Beneficiary form, I revoke all previously designated beneficiary(ies) and make the following designations, where permitted by law.

Last Name	**First Name**	**Relationship**	**DOB (MM/DD/YYYY)**	**Percentage**
If any primary beneficiary is under age 18, please name a trustee:				100%

In the event of my death, the above listed beneficiaries will receive any benefits payable from the Group Life Insurance Coverage, if living. Otherwise, the following is/are my Contingent Beneficiary (ies)

Last Name	**First Name**	**Relationship**	**DOB (MM/DD/YYYY)**	**Percentage**
If any Contingent beneficiary is under age 18, please name a trustee:				100%

Employee Signature

_____ _____

Date (MM/DD/YYYY) Signature of Employee

Employer Signature

_____ _____

Date (MM/DD/YYYY) Signature of Authorized Facility Official