HEALTH ASSOCIATION NOVA SCOTIA

Leave of Absence (LOA) Continuation of Group Benefits during an Unpaid Leave of Absence

Please read carefully. This form is to be fully completed for an approved unpaid leave other than injury or sickness. **Please initial on the line(s) that correspond with your selection.**

TO BE COMPLETED BY THE EMPLOYEE. **PLEASE PRINT AND USE CAPITAL LETTERS.**

Last Name	**First Name**	**Middle Initial**	**SIN**
			- -

Period of Leave From: ____/____/____ (MM DD YYYY) To: ____/____/____ (MM DD YYYY)

Purpose of the Leave: ☐ Maternity ☐ Layoff ☐ Other Leave (excluding injury or sickness). Please explain: ____________

☐ LONG TERM DISABILITY ☐ NOT APPLICABLE

_____ *(Initials)* I wish to continue coverage under the **LONG TERM DISABILITY PLAN** and will pay the required premiums as agreed upon with my employer. I understand the maximum period I can continue coverage while on my leave is twenty-four (24) months.

_____ *(Initials)* I **do not** wish to continue coverage under the **LONG TERM DISABILITY PLAN** for the period of leave indicated. I understand that I will not be covered by the LTD Plan until I return to work. I also understand that, should my leave of absence be greater than 24 months, I will be subject to a pre-existing condition limitation and any disability commencing within the first twelve (12) months of my return to work will not be covered if the disability is caused or contributed to by, or is a consequence of, illness or injury for which I received medical care, treatment or services or took any prescribed medications at any time during the ninety (90) day period prior to returning to work and becoming covered under the plan.

To be completed by the employer: If not continuing coverage, please note the effective date. *Effective Date (MM/DD/YYYY):* ____________

☐ BASIC LIFE INSURANCE ☐ NOT APPLICABLE

_____ *(Initials)* I wish to continue coverage under the **BASIC LIFE and DEPENDENT LIFE PLAN** and will pay the required premiums as agreed upon with my employer. I understand the maximum period I can continue coverage while on my leave is twelve (12) months.

_____ *(Initials)* I **do not** wish to continue coverage under the **BASIC LIFE and DEPENDENT LIFE PLAN** for the period of leave indicated. I understand that if my leave is greater than twelve (12) months I will be required to complete a three month waiting period before coverage under this Plan begins. If my leave is less than twelve (12) months, I understand that coverage will be reinstated automatically on the date I return to work.

To be completed by the employer: If not continuing coverage, please note the effective date. *Effective Date (MM/DD/YYYY):* ____________

☐ DENTAL ☐ NOT APPLICABLE

_____ *(Initials)* I wish to continue coverage under the **DENTAL PLAN** and will pay the required premiums as agreed upon with my employer. I understand the maximum period I can continue coverage while on my leave is twelve (12) months.

_____ *(Initials)* I **do not** wish to continue coverage under the **DENTAL PLAN** for the period of leave indicated. I understand my coverage will be reinstated following my return to work.

To be completed by the employer: If not continuing coverage, please note the effective date. *Effective Date (MM/DD/YYYY):* ____________

☐ HEALTH ☐ NOT APPLICABLE

_____ *(Initials)* I wish to continue coverage under the **HEALTH PLAN** and will pay the required premiums as agreed upon with my employer. I understand the maximum period I can continue coverage while on my leave is twelve (12) months.

_____ *(Initials)* I **do not** wish to continue coverage under the **HEALTH PLAN** for the period of leave indicated. I understand my coverage will be reinstated following my return to work.

To be completed by the employer: If not continuing coverage, please note the effective date. *Effective Date (MM/DD/YYYY):* ____________

☐ OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE ☐ NOT APPLICABLE

_____ *(Initials)* I wish to continue coverage under the **OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT PLAN** and will pay the required premiums as agreed upon with my employer. I understand the maximum period I can continue coverage while on my leave is twelve (12) months.

_____ *(Initials)* I **do not** wish to continue coverage under the **OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT PLAN** for the period of leave indicated. If my leave is twelve (12) months or less, I understand that coverage will be reinstated automatically on the date of return to work. I also understand that if my leave is greater than twelve (12) months I must reapply when I return to work.

To be completed by the employer: If not continuing coverage, please note the effective date. *Effective Date (MM/DD/YYYY):* ____________

☐ CRITICAL ILLNESS FOR MYSELF ☐ NOT APPLICABLE

_____ *(Initials)* I wish to continue coverage under the **OPTIONAL EMPLOYEE CRITICAL ILLNESS** and will pay the required premiums as agreed upon with my employer. I understand the maximum period I can continue coverage while on my leave is twenty-four (24) months.

_____ *(Initials)* I **do not** wish to continue coverage under the **OPTIONAL EMPLOYEE CRITICAL ILLNESS** for the period of leave indicated. I understand that I must apply for coverage when I return to work.

To be completed by the employer: If not continuing coverage, please note the effective date. *Effective Date (MM/DD/YYYY):* ____________

PLEASE COMPLETE PAGE 2 ON OTHER SIDE →

❑ CRITICAL ILLNESS FOR MY SPOUSE ❑ NOT APPLICABLE

_______ *(Initials)* I wish to continue coverage under the **OPTIONAL SPOUSAL CRITICAL ILLNESS PLAN** and will pay the required premiums as agreed upon with my employer. I understand the maximum period I can continue coverage while on my leave is twenty-four (24) months.

_______ *(Initials)* I **do not** wish to continue coverage under the **OPTIONAL SPOUSAL CRITICAL ILLNESS PLAN** for the period of leave indicated. I understand that I must apply for coverage when I return to work.

To be completed by the employer: If not continuing coverage, please note the effective date. *Effective Date (MM/DD/YYYY):* ____________

❑ CRITICAL ILLNESS FOR MY DEPENDENT CHILDREN ❑ NOT APPLICABLE

_______ *(Initials)* I wish to continue coverage under the **OPTIONAL DEPENDENT CHILDREN CRITICAL ILLNESS PLAN** and will pay the required premiums as agreed upon with my employer. I understand the maximum period I can continue coverage while on my leave is 24 months.

_______ *(Initials)* I **do not** wish to continue coverage under the **OPTIONAL DEPENDENT CHILDREN CRITICAL ILLNESS PLAN** for the period of leave indicated. I understand that I must apply for coverage when I return to work.

To be completed by the employer: If not continuing coverage, please note the effective date. *Effective Date (MM/DD/YYYY):* ____________

❑ OPTIONAL LIFE INSURANCE FOR MYSELF ❑ NOT APPLICABLE

_______ *(Initials)* I wish to continue coverage under the **OPTIONAL EMPLOYEE LIFE INSURANCE PLAN** and will pay the required premiums as agreed upon with my employer. I understand the maximum period I can continue coverage while on my leave is twelve (12) months.

_______ *(Initials)* I **do not** wish to continue coverage under the **OPTIONAL EMPLOYEE LIFE INSURANCE PLAN** for the period of leave indicated. I understand that if my leave is twelve (12) months or less my coverage will be reinstated automatically on the date of return to work. I also understand that if my leave is greater than twelve (12) months, I must reapply within sixty (60) days from the date I return to work. I understand that I have 31 days from the date coverage ceases to convert my life insurance to an individual plan if I wish to do so.

To be completed by the employer: If not continuing coverage, please note the effective date. *Effective Date (MM/DD/YYYY):* ____________

❑ OPTIONAL LIFE INSURANCE FOR MY SPOUSE ❑ NOT APPLICABLE

_______ *(Initials)* I wish to continue coverage under the **OPTIONAL SPOUSAL LIFE INSURANCE PLAN** and will pay the required premiums as agreed upon with my employer. I understand the maximum period I can continue coverage while on my leave is twelve (12) months.

_______ *(Initials)* I **do not** wish to continue coverage under the **OPTIONAL SPOUSAL LIFE INSURANCE PLAN** for the period of leave indicated. I understand that if my leave is twelve (12) months or less my coverage will be reinstated automatically on the date of return to work. I also understand that if my leave is greater than twelve (12) months, I must reapply within sixty (60) days from the date I return to work. I understand that I have 31 days from the date coverage ceases to convert my life insurance to an individual plan if I wish to do so.

To be completed by the employer: If not continuing coverage, please note the effective date. *Effective Date (MM/DD/YYYY):* ____________

❑ OPTIONAL LIFE INSURANCE FOR MY DEPENDENT CHILDREN ❑ NOT APPLICABLE

_______ *(Initials)* I wish to continue coverage under the **OPTIONAL DEPENDENT LIFE INSURANCE PLAN** and will pay the required premiums as agreed upon with my employer. I understand the maximum period I can continue coverage while on my leave is twelve (12) months.

_______ *(Initials)* I **do not** wish to continue coverage under the **OPTIONAL DEPENDENT LIFE INSURANCE PLAN** for the period of leave indicated. I understand that if my leave is twelve (12) months or less my coverage will be reinstated automatically on the date of return to work. I also understand that if my leave is greater than twelve (12) months, I must reapply within sixty (60) days from the date I return to work.

To be completed by the employer: If not continuing coverage, please note the effective date. *Effective Date (MM/DD/YYYY):* ____________

DECLARATION AND AUTHORIZATION

I hereby consent to the information provided in this form being collected, used or disclosed by Health Association Nova Scotia and/or any of its agents and service providers, including but not limited to insurers, benefits providers or administrators, benefits consultants and medical professionals, and shared between these parties for purposes of assessing eligibility for benefits to which I may be entitled, administering changes to benefits coverage, adjudicating any claims, auditing/reviewing the benefit plan as necessary for the proper and efficient design and administration of the plan, assessing, developing and administering related programs, and maintaining an effective claims management process.

I have verified the information on this form and declare that it is accurate and complete. I authorize the use of my social insurance number for group insurance identification purposes and as required by law for income tax reporting.

I understand that any changes to my selection above require that I complete and sign a revised Leave of Absence form.

______________________________ ______________________________

Date (MM/DD/YYYY) Signature of Employee

TO BE COMPLETED BY THE EMPLOYER. PLEASE PRINT.

Name of Employer	Employer Code
Name of Employee	SIN

______________________________ ______________________________

Name of Authorized Benefits Administrator (Please Print) Signature of Authorized Benefits Administrator

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Date (MM/DD/YYYY)