HEALTH ASSOCIATION NOVA SCOTIA

LEAVE OF ABSENCE (LOA) BENEFITS ELECTION FORM UNPAID LEAVE DUE TO INJURY OR SICKNESS

LOAF

PLEASE READ CAREFULLY. THIS FORM IS TO BE FULLY COMPLETED FOR UNPAID LEAVES IF THE UNPAID LEAVE IS DUE TO AN 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
			- -

Last Day Worked: ____ / ____ / ____ (MM / DD / YYYY) Date Sick Pay Ceased: ____ / ____ / ____ (MM / DD / YYYY)

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

Have you applied for disability benefits from: ☐ WCB ☐ CPP ☐ Other Leave. Please explain: _____

What is the status of your claim? ☐ Pending ☐ Approved

☐ LONG TERM DISABILITY ☐ NOT APPLICABLE

_____ *(Initials)* I wish to continue coverage under the **LONG TERM DISABILITY PLAN** during my leave. I understand the maximum period I can continue coverage while on my leave is twenty-four (24) months.

_____ *(Initials)* I **do not** wish to pay the required premiums under the **LONG TERM DISABILITY PLAN** for the period of leave indicated. I understand that if I apply and am approved for LTD benefits, premiums will be deducted from my first monthly benefit payment. If my application for LTD benefits is denied, I am aware that I have been insured during this period and the premiums are due and payable, and I will pay these premiums as agreed upon with my employer.

To be completed by the employer: If deferring premiums, 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.

_____ *(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. I also understand I will not be eligible for a waiver of premiums under the **BASIC LIFE and DEPENDENT LIFE PLAN** and coverage will be reinstated once 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.

_____ *(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.

_____ *(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.

_____ *(Initials)* I **do not** wish to continue coverage under the **OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT PLAN** for the period of leave indicated. I understand that if my leave is greater than twelve (12) months I will be required to reapply for coverage upon my return. I understand I will not be eligible for a waiver of premiums under the **OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT PLAN**. I also understand that coverage will be reinstated once I return to work if my leave is twelve (12) months or less.

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 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 EMPLOYEE CRITIAL ILLNESS PLAN** for the period of leave indicated. I understand I will not be eligible for a waiver of premiums under the **OPTIONAL EMPLOYEE CRITICAL ILLNESS PLAN**. I understand that I must reapply 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 I will not be eligible for a waiver of premiums under the **OPTIONAL SPOUSAL CRITICAL ILLNESS PLAN**. I understand that I must reapply 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 I will not be eligible for a waiver of premiums under the **OPTIONAL DEPENDENT CHILDREN CRITICAL ILLNESS PLAN**. I understand that I must reapply 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.

_____ *(Initials)* I **do not** wish to continue coverage under the **EMPLOYEE OPTIONAL LIFE PLAN** for the period of leave indicated. I understand that coverage will be reinstated once I return to work if my leave is twelve (12) months or less. I understand I will not be eligible for a waiver of premiums under the **EMPLOYEE OPTIONAL LIFE PLAN**. I also understand that if my leave is greater than twelve (12) months I will be required to reapply for coverage upon my return.

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.

_____ *(Initials)* I **do not** wish to continue coverage under the **OPTIONAL SPOUSAL LIFE INSURANCE PLAN** for the period of leave indicated. I understand that coverage will be reinstated once I return to work if my leave is twelve (12) months or less. I understand I will not be eligible for a waiver of premiums under the **OPTIONAL SPOUSAL LIFE INSURANCE PLAN**. I also understand that if my leave is greater than twelve (12) months I will be required to reapply for coverage upon my return.

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.

_____ *(Initials)* I **do not** wish to continue coverage under the **OPTIONAL DEPENDENT LIFE INSURANCE PLAN** for the period of leave indicated. I understand that coverage will be reinstated once I return to work if my leave is twelve (12) months or less. I understand I will not be eligible for a waiver of premiums under the **OPTIONAL DEPENDENT LIFE INSURANCE PLAN**. I also understand that if my leave is greater than twelve (12) months I will be required to reapply for coverage upon my return.

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

_____

Date (MM/DD/YYYY):