LTD Approval – Benefits Election Form

Reenrollment Health and/or Dental

Pease read carefully. This form is to be fully completed when an employee is approved for LTD benefits and opted out of the health and/or dental during their elimination period and is applying within 60 days from the LTD approval letter date. Please initial on the line(s) that correspond with your selection.

Last Name	First Name	Middle Initial

CERT (Find this on your health/dental card)

☐ **DENTAL** ☐ **NOT APPLICABLE**

_____ *(Initials)* I wish to reenroll in the **DENTAL PLAN** and will pay the required premiums as agreed upon with my employer.

_____ *(Initials)* I **do not** wish to reenroll in the **DENTAL PLAN**. I understand that coverage will be reinstated only once I return to work or if I lose coverage under my spouse's plan and I'm applying within 60 days from the date coverage was terminated.

☐ **HEALTH** ☐ **NOT APPLICABLE**

_____ *(Initials)* I wish to reenroll in the **HEALTH PLAN** and will pay the required premiums as agreed upon with my employer.

_____ *(Initials)* I **do not** wish to reenroll in the **HEALTH PLAN**. I understand that coverage will be reinstated only once I return to work or if I lose coverage under my spouse's plan and I'm applying within 60 days from the date coverage was terminated.

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.

______________________________ ______________________________
Date (MM/DD/YYYY) Signature of Employee

To be completed by the Employer. Please print.

Name of Employer	Employer code
Name of Employee	Payroll #

LTD Approval Letter Date: ________ / ________ / ________
MM DD YYYY

______________________________ ______________________________
Date (MM/DD/YYYY) Signature of Employer

Health Association Nova Scotia is a registered business name of Nova Scotia Association of Health Organizations.