HEALTH ASSOCIATION NOVA SCOTIA

APPLICATION FOR CONTINUATION OF BENEFITS DURING A MATERNITY/PREGNANCY, PARENTAL, ADOPTION LEAVE

LOAF

Please read your options carefully. This form is to be fully completed for an an employee going on a maternity/pregnancy, parental, adoption or sick leave prior to pregnancy leave. **Please initial on the line(s) that correspond with your selection.**

TO BE COMPLETED BY THE EMPLOYER. PLEASE FILL ELECTRONICALLY OR HAND PRINT USING UPPERCASE LETTERS.

Last Name	First Name	Middle Initial	Certificate #

Purpose of the Leave:	Period of Leave (MM/DD/YYYY)
☐ Unpaid Sick Leave	From: ____/____/____ To: ____/____/____
☐ Maternity/Parental Leave (Standard)	From: ____/____/____ To: ____/____/____
☐ Maternity/Parental Leave (Extended)	From: ____/____/____ To: ____/____/____
☐ Parental Leave	From: ____/____/____ To: ____/____/____
☐ Adoption Leave	From: ____/____/____ To: ____/____/____

☐ TOP UP ☐ YES ☐ NO	From: ____/____/____ To: ____/____/____

TO BE COMPLETED BY THE EMPLOYEE (AND EMPLOYER WHERE REQUIRED). PLEASE PRINT AND USE CAPITAL LETTERS.

☐ 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 BASIC DEPENDENT LIFE PLAN** during my leave and will pay the required premiums as agreed upon with my employer during my pregnancy, parental or adoption leave.

____ *(Initials)* I **do not** wish to continue coverage under the **BASIC LIFE and BASIC 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** during my leave and will pay the required premiums as agreed upon with my employer during my pregnancy, parental or adoption leave.

____ *(Initials)* I **do not** wish to continue coverage under the **DENTAL PLAN** for the period of leave indicated. I understand that coverage will be reinstated following my date of 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** during my leave and will pay the required premiums as agreed upon with my employer during my pregnancy, parental or adoption leave.

____ *(Initials)* I **do not** wish to continue coverage under the **HEALTH PLAN** for the period of leave indicated. I understand that coverage will be reinstated following my date of 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** during my leave and will pay the required premiums as agreed upon with my employer during my pregnancy, parental or adoption leave.

____ *(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):* _____

Please complete page 2 on the other side

Employee name: _____ Cert: _____

☐ **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):* _____

☐ **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** during my leave and will pay the required premiums as agreed upon with my employer during my pregnancy, parental or adoption leave.

_____ *(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.

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** during my leave and will pay the required premiums as agreed upon with my employer during my pregnancy, parental or adoption leave.

_____ *(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.

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** during my leave and will pay the required premiums as agreed upon with my employer during my pregnancy, parental or adoption leave.

_____ *(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 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	Payroll #	Employer Code

_____ _____ / / _____

Name of Authorized Benefits Administrator (Please Print) Date (MM/DD/YYYY)