HEALTH ASSOCIATION NOVA SCOTIA

APPLICATION FOR CONTINUATION OF GROUP BENEFITS – RETIRED MEMBERS *NSH LTCS*

RETE

Last Name	First Name	Middle Initial	Certificate Number

Address	City	Province

Postal Code	E-Mail Address	Telephone Number

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

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 MM	DD	YYY	Dependent Status**
	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	Certificate Number

GROUP LIFE INSURANCE COVERAGE

☐ I have elected to continue coverage until I reach age 65 and I am responsible for paying my monthly premiums to maintain coverage until age 65.

Life Coverage: _____

☐ 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	Contact Information	Relationship	DOB (MM/DD/YYYY)	Percentage
If any primary beneficiary is under age 19, 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	Contact Information	Relationship	DOB (MM/DD/YYYY)	Percentage
If any Contingent beneficiary is under age 19, please name a trustee:					100%

Payment Information

Premiums will be deducted from my bank account through Pre-Approved Withdrawal. *Please see your Benefits Administrator for Retiree Health Rates.*

Bank Number	Transit/Branch Number	Account Number

*****Please enclose a void cheque.**

Employee Signature

_____ _____

Date (MM/DD/YYYY) Signature of Employee