

**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	Certificate Number

Period of Leave From: / / To: / /

 MM DD YYYY MM DD YYYY

Purpose of the Leave: Personal 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 on the 1st of the month 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 the 1st of the month 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):* _____

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