HEALTH ASSOCIATION NOVA SCOTIA

LEAVE OF ABSENCE (LOA) CONTINUATION OF GROUP BENEFITS DURING A LAYOFF PERIOD

PLEASE READ CAREFULLY. THIS FORM IS TO BE FULLY COMPLETED DURING A LAYOFF PERIOD. **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 layoff From: _____ (MM/DD/YYYY) To: _____ (MM/DD/YYYY)

LONG TERM DISABILITY - Cannot continue during a lay period

❑ BASIC LIFE INSURANCE ❑ NOT APPLICABLE

_____ *(Initials)* I wish to continue coverage under the **BASIC 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 6 months.

_____ *(Initials)* I **do not** wish to continue coverage under the **BASIC 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 6 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 the first 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 6 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 first 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 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