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Leave of Absence – Disability and Optional Group Life Continuation

TO BE COMPLETED BY EMPLOYEE

PLAN MEMBER INFORMATION

First Name	Last Name	Date of Birth mm/dd/yyyy	Benefit ID#

You must complete this Leave of Absence form and return it to your payroll department at your employer within 30 days of the start of your leave of absence. If you do not make your election within 30 days of the start of your leave, you will be deemed to have waived optional life, voluntary accidental death and dismemberment (AD&D) insurance AND disability coverage. Accordingly, your optional life, voluntary AD&D insurance AND disability coverage will automatically terminate effective the first day of your leave of absence.

Disability Plan membership (if applicable): ❑ CUPE ❑ SEIU ❑ SUN ❑ General

Date leave began: mm/dd/yyyy	Expected return to work date: mm/dd/yyyy

Disability

For the period of my leave of absence, I elect the following option (select one):

❑ I wish to maintain my disability income plan coverage. I fully understand that it is my responsibility to ensure that all premiums are paid to my Employer during the period of my leave of absence.

❑ I do not wish to maintain my disability income plan coverage. I fully understand that I am relinquishing all claims to coverage.

Employee and Spousal Optional Group Life

For the period of my leave of absence, I elect the following option (select one):

❑ I wish to maintain my optional group life insurance coverage. I fully understand that it is my responsibility to ensure that all premiums are paid to my Employer during the period of my leave of absence.

❑ I do not wish to maintain my optional group life insurance coverage. I fully understand that I am relinquishing all claims to coverage and that medical evidence, subject to the approval of the insurer, will be required if optional group life insurance coverage is requested upon my return to work.

Plan member signature:	Date signed: mm/dd/yyyy

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