Public Service Group Insurance Fund
Election to Continue or Waive Group Insurance Coverage
During an Employer Approved Leave of Absence or Lay-Off

To Be Completed by the Employee:

Name of Employee _____
(Last Name) (Given Name in Full)

Employee Number _____ S.I.N. _____ Date of Birth _____

_____ to _____
Expected Start Date of Leave Expected Return Date

Insurance may be continued for up to two years during an approved leave of absence. The insurance may be continued for up to a further two years, subject to employer approval. ***Please elect Option A or B below:***

Option A:

☐ I hereby make application to **CONTINUE** my present insurance coverage under the insurance plans for my period of leave/lay-off, up to the maximum 48-month period. I will pay both the employer and employee insurance premiums during this period.

Life Insurance Premiums: 10.59¢ bi-weekly/$1,000 of Group Life Insurance coverage.
Accidental Death and Disablement Premiums: 1.58¢ bi-weekly/$1,000 of AD&D coverage
Dependents Insurance Premiums: $1.60 bi-weekly per Unit of Dependents Insurance coverage

NOTE: Payment of premiums must be arranged with your employer prior to the commencement of the leave. Insurance premiums are required unless you elect to waive coverage during your leave of absence/lay-off. Insurance during a leave/lay-off cannot be extended beyond a 48-month period.

Option B:

☐ I hereby make application to **WAIVE** (not continue) my present insurance coverage under the insurance plans for my period of leave/lay-off. I understand that a retroactive election to waive coverage will not be accepted, and that I am responsible for the payment of any accumulated insurance arrears until this completed form is received by my employer. I will not be entitled to a refund of any premiums unavoidably deducted due to insufficient notice of my election to waive premiums during my leave of absence/lay-off.

_____ _____
Signature of Insured Member Date

To Be Completed by the Employer:

Employer _____ BA _____

Employer Approved Leave of Absence / Layoff:

_____ to _____
Start Date Return Date[1]

Insurance in effect during the period of leave of absence / lay-off:

Insurance Annual Salary _____ Class _____ Units _____

_____ _____
Contact Person (Please Print) Phone Number

[1] **If return date is unknown, please notify the Board Office once the return date has been confirmed.**