

APPLICATION FOR CONTINUATION OF BENEFITS DURING LEAVE



We request that the group benefits for the employee listed below be continued during the dates specified while on Leave. The request must be made prior to it being offered to the employee.

1

Employer Name _____

Employee Name _____ Certificate # _____

For Period Beginning (MM/DD/YYYY) ____/____/____ Ending (MM/DD/YYYY) ____/____/____

2

Type of Leave

LEAVE OF ABSENCE* TEMPORARY LAY-OFF* MATERNITY / PARENTAL LEAVE ** COMPASSIONATE CARE**

* **Cannot exceed 6 Months**

** **For Maternity/Parental/Compassionate Leave, benefits are administered in accordance with applicable legislation.**

3

Benefits may continue up to the date of approval, but will terminate if the Group Policy terminates or if the plan member's employment is terminated.

Authorized Employer Signature _____ Date _____

INTERNAL USE ONLY

Approval Date
(MM/DD/YYYY)

BASIC LIFE _____

AD&D _____

DEPENDENT LIFE _____

STD (Maternity/Parental/Compassionate Leave only) _____

LTD (Maternity/Parental/Compassionate Leave only) _____

EXTENDED HEALTH _____

DENTAL _____

EFAP _____