December 23, 2019

**To:** **Benefit Administrators / Human Resource Personnel**

**From:** **Sarah Dedman**
**Support Services Manager, Employee Benefits**

**Re:** **Leave of Absence - Disability and Optional Group Life Continuation form**
**Employee Benefit Plans**

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3sHealth Administration worked with our legal advisor to develop standard wording to advise the employee what will happen to their optional life insurance and disability coverage if they do not return their *Leave of Absence – Disability and Optional Group Life Continuation* form within 30 days of the first day of their leave.

The recommended wording from our legal advisor has been added to the *Leave of Absence - Disability and Optional Group Life Continuation* form.

This form is available on the 3sHealth website: www.3shealth.ca.

Please replace any previous forms with the new forms.

If you have any questions about the Leave of Absence form, please contact Sarah Dedman at sarah.dedman@3shealth.ca or 306.347.5553.

3sHealth – Employee Benefits
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3sHealth Shared Services Saskatchewan *better together*

# Leave of Absence – Disability and Optional Group Life Continuation

## TO BE COMPLETED BY EMPLOYEE

## PLAN MEMBER INFORMATION

| First Name | Last Name | Date of Birth dd/mm/yy | 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: dd/mm/yy | Expected return to work date: dd/mm/yy |
|---|---|

## 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.

## 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: dd/mm/yy |
|---|---|

*For 3sHealth Employee Benefit use only*

**Mail original form to:** 3sHealth Employee Benefits 700-2002 Victoria Avenue Regina SK S4P 0R7 – Email: ebp@3shealth.ca