TIME SENSITIVE—ACT NOW

You have 60 days from the date your approved leave without pay commenced to decide if you wish to continue some or all of your benefits during this period. Failure to do so will result in suspension or termination of coverage as applicable. Retroactive payments will not be accepted.

Continuation of Employee Benefits Coverage (COEB)

Leave of Absence Without Pay as the Result of the GNB COVID-19 Vaccination Policy

You and your employer are responsible for completing this form. Your employer must complete their sections first so that you are aware of the total premium required.

Name: _____ S.I.N: _____

Employer: _____ Bargaining Unit: _____

Start of Leave (DD/MM/YYYY): _____ End of Leave - if known (DD/MM/YYYY): _____

Preferred Telephone (while on leave): _____ Preferred Email (while on leave): _____

If you choose to continue coverage for some or all benefits:

- Check and initial each box on page 2 for the benefits you wish to continue.
- Date and sign page 2 once you have made your choices.
- Send a copy of this 2-page form attached to your premium payments **to Vestcor** for the Group Life benefits and Accidental Death & Dismemberment (AD&D). **Vestcor requires monthly post-dated cheques or monthly money orders.**
- Send a copy of this 2-page form attached to your premium payments **to your employer** for Health, Travel, and Dental.
- Go to the website Vestcor.org/continuation-coverage for the maximum periods for Leave of Absence Continuation of Coverage or contact your employer for the information.
- Contact your employer if you experience a qualifying life-changing event Vestcor.org/enrolment-change.
- **Optional Critical Illness coverage will automatically be continued.** If you wish to discontinue/cancel coverage, you must call Medavie Blue Cross' Optional Benefits Team at 1 (844) 949 3809.

NOTE: CONTINUATION OF COVERAGE FOR LTD AND WAIVER OF PREMIUM IS NOT AVAILABLE

If you choose to discontinue coverage for some or all benefits:

- Check and initial each box on page 2 for the benefits you wish to discontinue.
- Coverage is suspended the day your leave without pay commenced and is reinstated when you are back at work.
- **Optional Critical Illness coverage will automatically be continued.** If you wish to discontinue/cancel coverage, you must call Medavie Blue Cross' Optional Benefits Team at 1 (844) 949 3809.

If you choose to cancel continuation of your coverage at any time on a go forward basis, inform Vestcor and your employer in writing. **If you cancel your coverage you will not be able to reinstate the coverage until your return to work.**

If you have any questions, please contact Vestcor's Member Services Team at 1 (800) 561 4012.

PAGE 2: PREMIUMS REQUIRED

Premiums required

Type of coverage	Employer to complete			Employee to complete		
	Coverage amount ($)	Monthly premium ($)	Last premium paid (MM/YYYY)	Continuing coverage?	Employee initials	If yes - employee premium amount required ($)
Basic Group Life/AD&D*				☐ Yes ☐ No ☐ N/A		$
Optional Group Life/AD&D				☐ Yes ☐ No ☐ N/A		$
Dependent Life				☐ Yes ☐ No ☐ N/A		$
Voluntary AD&D				☐ Yes ☐ No ☐ N/A		$
Long-Term Disability	- N/A -	- N/A -	- N/A -	■ Yes ■ No ☑ N/A	- N/A -	$ - N/A -

Monthly post-dated cheques or monthly money orders to continue Group Life and/or AD&D must be made payable to the Minister of Finance, dated the 1st of each month , and sent to:

Monthly cheque total **$**

Vestcor - PO Box 6000, Fredericton, NB E3B 5H1

Premium payment attached for the month(s) of: _____

Additional notes: _____

***IMPORTANT! Basic Group Life/AD&D is mandatory in order to continue Optional Group Life, Dependent Life or Voluntary AD&D.**

Premiums required (Health, Travel and Dental)

Type of coverage	Employer to complete		Employee to complete		
	Monthly premium ($)	Last premium paid (MM/YYYY)	Continuing coverage?	Employee initials	If yes - employee premium amount required($)
Health and Travel			☐ Yes ☐ No ☐ N/A		$
Dental			☐ Yes ☐ No ☐ N/A		$

Cheques or money order to continue Health, Travel and Dental coverage must be made payable as per your employer's instructions, dated the 1st of each month and sent to your employer at the following address:

Monthly cheque total **$**

Employer to complete

Premium payment attached for the month(s) of: _____

Additional notes: _____

Employer Signature

Employer signature: _____ Date (DD/MM/YYYY): _____

Employee Signature

I have been given the opportunity to choose if I want to continue or discontinue employee benefits during my leave of absence without pay.

I understand that any coverage I have chosen not to continue will be suspended during the leave without pay period with reinstatement of coverage when I return to work.

Cheques returned due to insufficient funds will result in suspension of coverage.

Employee signature: _____ Date (DD/MM/YYYY): _____