**Continuation of Employee Benefits Coverage (COEB)**
Leave of Absence Without Pay or Lay Off

# TIME SENSITIVE—ACT NOW

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

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.

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

- Check and initial each box on pages 2 and 3 for the benefits you wish to continue.
- Date and sign page 3 once you have made your choices.
- Send a copy of pages 2 and 3 of this form attached to your premium payments **to Vestcor*** for the Group Life Insurance, Long Term Disability (LTD) and Accidental Death & Dismemberment Insurance (AD&D). **Vestcor* requires monthly post-dated cheques or monthly money orders**.
- Send a copy of pages 2 and 3 of this form attached to your premium payments **to your employer (HR/Payroll Office)** for Health, Travel, and Dental coverage. **Contact your employer for applicable methods of payment**.
- Go to 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).
  - Will be absent from work for more than 4-months due to illness or injury.
- **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 discontinue coverage for some or all benefits:

- Check and initial each box on pages 2-3 for the benefits you wish to discontinue.
- Date and sign page 3 once you have made your choices.
- Send a copy of pages 2 and 3 of this form **to Vestcor*** if you wish to discontinue coverage for the Group Life Insurance, Long Term Disability (LTD) and Accidental Death & Dismemberment Insurance (AD&D).
- Send a copy of pages 2 and 3 of this form to **your employer (HR/Payroll Office)** if you wish to discontinue coverage for Health, Travel, and Dental coverage.
- Coverage will end on the last day of the month for which the last premium payment paid for and will then be suspended. Coverage will only be reinstated upon your return to work.
- You are waiving your right to submit a claim for LTD and/or Waiver of Premium (WOP) benefits.
- **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 506-453-2296 or 1-800-561-4012. Vestcor's mailing address is PO Box 6000, Fredericton, NB E3B 5H1. They can also be contacted by email at info@vestcor.org.**

**IMPORTANT: Information submitted via email is not considered secure unless encrypted. If you would like to submit this form via email and do not have a method to encrypt it, please contact our office in order to submit this form electronically in a secure format.**

| **Continuation of Employee Benefits Coverage (COEB)**<br>Leave of Absence Without Pay or Lay Off<br>**With Cost Sharing in Place (e.g. Maternity Leave)** | **IMPORTANT!** *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 | |
| Social Insurance Number (Optional) | Vestcor Reference Number **OR** Employee ID |
| Employer | Bargaining Unit |
| Type of leave: ☐ Sick ☐ Maternity ☐ Lay-off ☐ Other: _____ | |
| Start of Leave (DD/MM/YYYY) | End of Leave - if known (DD/MM/YYYY) |
| Start of Lay-off (DD/MM/YYYY) | End of Lay-off (DD/MM/YYYY) |
| Preferred Telephone (while on leave) | Preferred Email (while on leave) |

**Premiums required during the cost sharing period (Group Life Insurance, AD&D and LTD)**

| **Type of Coverage** | **Employer to complete** | | | **Employee to complete** | | |
|---|---|---|---|---|---|---|
| | **Coverage Amount ($)** | **Monthly Premium ($)** | **Last Premium paid (MM/YY)** | **Continuing Coverage?** | **Employee initials** | **If yes - Employee Premium Required ($)** |
| Basic Group Life/ AD&D* | | | | ☐ Yes ☐ No ☐ N/A | | 100% employer paid |
| Optional Group Life/ AD&D | | | | ☐ Yes ☐ No ☐ N/A | | |
| Dependent Life | | | | ☐ Yes ☐ No ☐ N/A | | |
| Voluntary AD&D | | | | ☐ Yes ☐ No ☐ N/A | | |
| LTD (cannot be continued during lay-off period) | | | | ☐ Yes ☐ No ☐ N/A | | |

**Monthly cheque total ($)** _____

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

_____

_____

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

**Date employer cost sharing premiums end** (employer to complete): _____

**Additional notes:** _____

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

**Continued on the next page**

| Premiums required during the cost sharing period (Health, Travel and Dental) | | | | | |
|---|---|---|---|---|---|
| **Type of Coverage** | **Employer to complete** | | **Employee to complete** | | |
| | **Monthly Premium ($)** | **Last Premium Paid (MM/YYYY)** | **Continuing Coverage?** | **Employee Initials** | **If Yes - Employee Premium Required ($)** |
| Health and Travel | | | ☐ Yes ☐ No ☐ N/A | | |
| Dental | | | ☐ Yes ☐ No ☐ N/A | | |

**Monthly post-dated cheques or monthly money orders or pre-authorized debit/chequing (PAD or PAC) to continue Health, Travel and Dental coverage must be made as per your employer's instructions, dated the 1st of each month, and sent to your employer at the following address** *(employer to complete):*

**Monthly cheque total ($)** _____

_____

_____

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

**Date employer cost sharing premiums end** (employer to complete): _____

**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 or lay-off period.
- I understand that any coverage I have chosen not to continue will end on the last day of the month that the last premium payment paid for and then be suspended. Coverage will only be reinstated upon my return to work.
- Cheques returned due to insufficient funds will result in suspension (for a leave) or termination of coverage (for lay-off) as applicable.

**PRIVACY CONSENT:** The personal information collected on this form will be used by Vestcor to: identify the member and the member's employer; set up the continuation or termination (as applicable) of benefits coverage and confirm eligibility; deduct the appropriate amount from the member's bank account (as applicable); contact the member and/or employer as necessary; and ultimately ensure that the benefits program is administered in accordance with the plan's governing documents. The information may be disclosed to Finance and Treasury Board. If you have any questions about the collection and use of this information, contact Vestcor's Member Services team, by mail at P.O. Box 6000, Fredericton, NB, E3B 5H1, by phone at (506) 453-2296 or 1-800-561-4012, or by email at info@vestcor.org. In addition, please note that Vestcor's Privacy Statement is available at vestcor.org/privacy.

**Employee Signature:** _____ **Date** (DD/MM/YYYY): _____