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 or lay-off 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

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 page 2 and/or page 3, whichever page is applicable, for the benefits you wish to continue.
- Date and sign page 2 and/or page 3, whichever page is applicable, once you have made your choices.
- Send a copy of page 2 and/or page 3, whichever page is applicable, 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 page 2 and/or page 3, whichever page is applicable, 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 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.
  - 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 page 2 and/or page 3, whichever page is applicable, for the benefits you wish to discontinue.
- Date and sign page 2 and/or page 3, whichever page is applicable, once you have made your choices.
- Send a copy of page 2 and/or page 3, whichever page is applicable, 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 page 2 and/or page 3, whichever page is applicable, 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**

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

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 - if known** (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/YYYY)	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 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):* _____ **Monthly cheque total ($)** _____

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

Date employer cost sharing premiums ends (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.**

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: **Monthly cheque total ($)** _____

(employer to complete): _____

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.

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

Continuation of Employee Benefits Coverage (COEB)
Leave of Absence Without Pay or Lay Off
No Cost Sharing in Place

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: _____ **SIN:** _____

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 - if known** (DD/MM/YYYY)**:** _____

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

Premiums required when there are no cost sharing arrangements in place (Group Life Insurance, AD&D and LTD)

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 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		
LTD (cannot be continued during lay-off period)				☐ Yes ☐ No ☐ N/A		

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 complete):*

Monthly cheque total ($) _____

_____

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 when there are no cost sharing arrangements in place (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:

Monthly cheque total ($) _____

(employer to complete): _____

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

Additional notes: _____

Employer Signature

Employer Signature:_____ **Date** (DD/MM/YYY)**:** _____

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.

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