

NON STATE-PAID LEAVE OF ABSENCE

Waiver of Coverage

(only employees who go on a leave of absence for which they are responsible for 100% of the premiums may use this form)

For GIR/P Use Only	
Employee Information	Leave Type/Subtype Code: _____
Employee Name: _____	Social Security Number: _____
Premium Calculation	
Note to GIR: Use the Membership System Deduction Calculation Screen - 5C to calculate the <u>monthly</u> premiums of the member.	
Member Health & Dental: \$ _____	Member and Dependent Life: \$ _____
Dependent Health & Dental: \$ _____	

Section A: Your Rights & Responsibilities

It is your right to:

- Waive your group insurance coverage while on leave of absence for which you owe 100% of the premium.
- Become a dependent of your State-covered spouse (must elect to waive all coverage, including Basic Life).

It is your responsibility to:

- Pay your elected premiums timely, and to
- Notify your personnel office and *Group Insurance Representative (GIR)* immediately when you...
 - change your address, and/or
 - return to work from a leave of absence.

Section B: Reinstatement of Coverage

If you physically return to work on the first work day of a pay period, your current health/dental coverage elections will be reinstated the first day of that pay period. If you physically return to work after the first work day, coverage will be reinstated effective the first day of the following pay period. Your dependent and/or optional life coverage may be reinstated following your return to work as long as the coverage is requested within 60 days of your physical return to work. **Note:** If, at the time you go on a leave of absence, you elected to become a dependent of your state-covered spouse, coverage will be reactivated effective the date of your physical return to work.

Section C: Billing Procedure

If you elect to continue coverage while on leave, billing statements will be sent to you on a monthly basis by the CMS Premium Collection Unit. Payment must be received by the due date indicated on the statement. If payment is not received by the final due date, coverage will be terminated on the last day of the month of the final billing notice and an order for involuntary withholding will be filed to collect the premiums owed.

I understand the above and want to waive:			
<input type="checkbox"/> <u>all coverage for myself and my dependents.</u>			
<input type="checkbox"/> <u>only the following</u> (check all that apply):			
<input type="checkbox"/> My health and dental coverage	<input type="checkbox"/> My dependent's health and dental coverage		
<input type="checkbox"/> AD&D	<input type="checkbox"/> Spouse Life	<input type="checkbox"/> Child Life	<input type="checkbox"/> Member Optional Life
<input type="checkbox"/> All life coverage (includes Basic Life, Member Optional Life, Spouse Life, Child Life and AD&D)			
I have read, understand and agree to the information indicated in sections A, B and C above. I understand that my election to waive will be effective the date of my signature or the date of the leave of absence, whichever is later. I also understand that I must request dependent coverage upon my physical return to work. Furthermore, I must reapply for optional life coverage upon my physical return to work and that optional life will only be reinstated if my statement of health application is approved.			
Member Signature _____	Date _____		
GIR/GIP Signature _____	Date _____		