Public Service Group Insurance Fund
Election to Continue Group Insurance - Policy 330780/330785
During An Employer Approved Leave of Absence or Lay-Off

Personal Information – To be answered in full by employee. Please print and return to your employer.

Name of Employee _____
(Last Name) (Given Names in Full)

Employee Number _____ Certificate No./SIN _____ Date of Birth _____
YYYY MM DD

I hereby make application to continue my present insurance under the Insurance Plans for my period of leave/lay-off from

_____ to _____.
Expected Start Date Expected Return Date

By signing this form, I agree to pay the necessary premiums and any accrued arrears required to maintain the insurance coverage in force during my approved leave of absence or lay-off.

1. Life
   10.59¢ bi-weekly/$1,000 of annual salary for each Class*

2. Accidental Death and Disablement
   1.58¢ bi-weekly/$1,000 of annual salary to a maximum of $25,000 for Class 1, $50,000 for Class 2, and $75,000 for Classes 3, 4, and 5.

3. Dependents
   $1.60 bi-weekly/Unit

Payment of premiums must be arranged with employer prior to leave. Insurance during an employer approved leave of absence/lay-off shall continue but cannot be extended beyond a 48 month period.

*subject to age reductions and maximum insurance of $1,000,000

If I do not make a written election to either continue or waive my insurance premiums during my employer approved leave of absence or lay-off, I acknowledge that the insurance coverage will be deemed to have continued and I will be responsible for payment of the premiums and accrued arrears during the period of leave.

_____ _____
Signature of Insured Member Date

_____ _____
Witness to the Above Signature Date

For Employer Use Only: Personal cheques received from employees pertaining to leave of absence/lay-off must be included with your normal remittance. See the Group Insurance Administration Manual for further information.

This section is only to be completed if the employer is unable to include personal cheques with the normal remittance.

Employer _____ Employer Code _____

Pay Period - from _____ to _____

Insured Period - from _____ to _____

Employee Premium - $_____ Employer Premium - $_____

AD&D Premium - $_____ Dependents Premium - $_____

Cheque Number _____ Date _____

Contact Person _____ Phone Number _____

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