Public Service Group Insurance Fund
Election to Waive 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

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

Employee Number _________________ Certificate No./SIN ________________ Date of Birth __________________
YYYY MM DD

I do not wish to continue to be insured during my period of employer approved leave of absence/lay-off from

____ to ____.
Expected Start Date Expected Return Date

By signing this form, I acknowledge that

- I do not wish to continue to be insured during my period of employer approved leave of absence/lay-off.
- I am responsible for payment of any accumulated insurance arrears until this completed form is received by my employer. A retroactive election to waive premiums will not be accepted.
- I will not be entitled to a refund of any overpayment of premiums unavoidably deducted by my employer due to insuffcient notice of my election to waive premiums during my leave of absence/lay-off.

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