

NON STATE-PAID LEAVE OF ABSENCE

Waiver of Coverage

For GIR/P Use Only

Section A: Employee Information **Date Form Provided to Member:** _____

Employee Name: _____ **Social Security Number:** _____

Leave Type/Subtype Code _____ **PT %:** _____ **Effective Date:** _____

Section B: Premium Calculation

Note to GIR: Use the Membership System Deduction Calculation Screen - 5C to calculate the monthly premiums of the member.

Member Health & Dental: _____ **Member and Dependent Life:** _____

Dependent Health & Dental: _____

Section C: Your Rights & Responsibilities

It is your right to:

- Waive your group insurance coverage while on leave of absence owing 100% of the premium.
- Have your prior health/dental coverage elections reinstated when you return to work (see note below).
- Dependent coverage will not be reinstated unless you make a written request within 60 days of your return to work.
- Become a dependent of your State employed spouse if ...
 - you are responsible for 100% of the State and member portions of insurance coverage, and
 - elect to waive all coverage (including Basic Life).

Note: Coverage waived will be reactivated the first day of the pay period following your physical return to work. If you become a dependent of your state-employed spouse, coverage reactivates on the date of your physical return to work.

It is your responsibility to:

- Pay your elected premiums timely.
- Notify your Personnel Office and Group Insurance Representative/Preparer immediately when you ...
 - change your address
 - return to work from a leave of absence

Section D: Billing Procedure

If you elect to continue coverage, 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.

Section E: Election & Certification

I understand the above and (check one):

- I want to waive coverage for myself and my dependents. I understand I must request dependent coverage and/or reapply for optional life coverage upon my physical return to work.
- I want to waive my health and dental coverage, but continue my:
- Basic Life
- Optional Life
- I want to continue my health and dental coverage, but waive my:
- Dependent Health and Dental
- Optional Life (includes Member Optional Life, AD&D, Spouse Life and Child Life)

I have read, understand and agree to the Rights and Responsibilities as indicated in sections C and D above. I understand that my elections will be effective the date of signature or the date of the leave of absence whichever is later.

Member Signature _____ **Date** _____

GIR/GIP Signature _____ **Date** _____