State of Illinois
Department of Central Management Services

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: _____

Member Name: _____ SSN: _____

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 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

When you physically return to work, **your** current medical/dental coverage elections will be reinstated the date of your physical return. Your dependent and/or optional life coverage *will not automatically* be reinstated. Your dependent coverage may be reinstated following your physical return work as long as the coverage requested within 60 days of your return and all outstanding premiums have been received by CMS. **Note:** *If you were eligible and chose to become a dependent under your spouse's state-coverage, your coverage will be reactivated 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:

☐ all coverage for myself and my dependents.

☐ only the following (check all that apply):

- ☐ My health and dental coverage
- ☐ My dependent's health and dental coverage
- ☐ AD&D
- ☐ Spouse Life
- ☐ Child Life
- ☐ Member Optional Life
- ☐ 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: _____