[TO BE PRINTED ON SCHOOL DIVISION LETTERHEAD]

BENEFITS ELECTION FORM
CONTINUATION OF COVERAGE DURING COVID-19 LAYOFF PERIOD

Name of Employee: ____

Employees are entitled to elect whether they wish to continue to participate in the group benefits program during their temporary layoff period. If you choose to continue your benefits coverage during this period, you are required to continue to pay your portion of the required premiums for the full duration of the layoff. The continuation of your benefits is conditional on your School Division receiving this election form and your post-dated cheques (or another mutually agreed upon form of payment) **within 31 days of your layoff effective date**.

If you do not return this form within 31 days of your layoff effective date, or fail to make payment arrangements, your insurance coverage will be suspended until your return to active employment.

Participation Election

For the duration of my temporary layoff due to COVID-19, I elect the following <please check the applicable box(es)>:

MANITOBA PUBLIC SCHOOL EMPLOYEES GROUP LIFE INSURANCE PLAN

☐ **Continue Group Life Insurance coverage (and/or Family Life/Accident Insurance if applicable).** I understand that by choosing this option, I commit to providing my employer with required premium payments; or

☐ **Suspend Group Life Insurance coverage (and/or Family Life/Accident Insurance if applicable)**. I understand that by choosing this option, I will not have access to these benefits, coverage or protection until I return to regular active employment with the School Division.

MANITOBA SCHOOL BOARDS LONG TERM DISABILITY PLAN

☐ **Continue Long Term Disability coverage.** I understand that by choosing this option, I commit to providing my employer with required premium payments; or

☐ **Suspend Long Term Disability coverage.** I understand that by choosing this option, I will not have access to this benefit, coverage or protection until I return to regular active employment with the School Division.

Required Signature
I understand that the election entered on this form will apply throughout the duration of my temporary layoff. I understand that any election to continue benefits coverage during a layoff is conditional on premium payments, and that any election to not continue coverage or my failure to pay for the continued premiums will result in my insurance coverage being suspended until I return to my regular employment following the end of the temporary layoff.

I make this election freely, and with the knowledge and understanding of the consequences and expectations of this decision.

Signature of Employee: ______________________________ Date: ______________________________

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