OASSIS
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OASSIS
BENEFIT PLANS FOR NOT-FOR-PROFITS

CONTINUATION OF BENEFITS DURING AN EMPLOYER APPROVED LEAVE OPTION FORM

SECTION A: TO BE COMPLETED BY EMPLOYER

- This form must be completed and submitted to OASSIS before the employee commences their leave.
- *During a maternity or other statutory leave, coverage may be maintained as required by relevant legislation in each province (eg. Employment Standards). It is the employer's responsibility to review provincial guidelines ensuring compliance with legislation when confirming the dates of a statutory leave.*
- *During a sick leave (including WSIB), an employee must be on a carrier approved medical leave to meet eligibility for participation in the benefit plan. The period of continuation is subject to your plan maximum.*

Employee Last Name:	Employee First Name:
Certificate Number:	Agency Name:
Last Day Actively at work: (y/m/d)	Expected return to work date: (y/m/d)

Identify type of leave:

☐ Maternity and/or Parental Leave	☐ Educational Leave
☐ Family Caregiver Leave	☐ Unpaid Leave (reasons other than illness, vacation, or statutory leave)
☐ Family Medical Leave	☐ Temporary Lay-Off
☐ Critical Illness Leave	☐ Sick Leave (including WSIB lost time)
☐ Other (please specify)	

SECTION B: TO BE COMPLETED BY EMPLOYEE

CONTINUE BENEFITS COVERAGE WHILE ON LEAVE OF ABSENCE

☐ I wish to continue all benefits during my leave. I agree to continue my contributions in the form required by my employer. I understand that if I become totally disabled during my leave of absence, disability benefits will be payable only after my scheduled return to work.

WAIVE BENEFITS COVERAGE WHILE ON A LEAVE OF ABSENCE

☐ I do not wish to continue my benefits during my leave. I understand that all my benefit coverage under OASSIS will be terminated on the day my leave begins. I further understand that when I return to work, but not before, I may apply for reinstatement of the benefits I had when I commence my leave provided, I apply within 31 days of the date I return to work. I also understand that I will be required to provide satisfactory evidence of insurability for any Optional Life or Critical Illness if applicable), regardless of prior coverage under this benefit if the duration of my leave is greater than 6 months.

IF YOU ARE TAKING MATERNITY /PARENTAL LEAVE PLEASE CONFIRM THE FOLLOWING DATES

My expected date of delivery is: (y/m/d)	I plan to return to work on: (y/m/d)
I plan to begin my maternity leave on: (y/m/d)	I plan to begin my parental leave on: (must commence immediately following maternity leave) (y/m/d)

Signature of Employee	Date Signed
Authorized Agency Signature	Date Signed