Public Education
PEBT BENEFITS TRUST
Your benefits, your health

This form must be completed and signed by any employee who decides to waive Extended Health or Dental benefits because they have coverage under a spouse's plan or by any employee wishing to waive coverage while on a Leave of Absence, Maternity, Parental or EI Compassionate Care Leave. It may not be used if group insurance coverage is mandatory (e.g. where the employee does not contribute to the cost of the benefit plan), and is not required if the employee chooses not to apply for Optional Life or Optional Accident Death and Dismemberment insurance.
Please return completed form to your District Benefits Administrator.

Waiver of Coverage

Employee's Waiver of Rights

Employee's Last Name	First Name	Initial	District #

Covered Employee

❑ I am currently insured under the PEBT Benefits Program for my District, and

❑ My dependents and I now have coverage under another ❑ Dental ❑ Extended Health Care plan. I understand that we/I have the option of having coverage under more than one plan, but I have chosen to now waive coverage under the PEBT Benefits Program for my District for:

❑ Myself and my dependents ❑ my dependents only for ❑ Dental
❑ Myself and my dependents ❑ my dependents only for ❑ Extended Health

Termination Effective Date (yyyy/mm/dd): ____________________

Leave of Absence

❑ I am currently insured under the PEBT Benefits Program for my District, and

❑ I am going on a leave of absence/Maternity/Parental/EI Compassionate Care Leave and have chosen to waive coverage under the PEBT Benefits Program for my district during this period of time for the following list of benefits:

Please list benefit coverage to be waived:

____

Termination Effective Date (yyyy/mm/dd): ____________________

I understand that if I waive long term disability benefits (if applicable) during my leave and become disabled, the disability will not be covered by the plan and no benefits will be paid at any time. Coverage will not be reinstated until I return to active employment.

I hereby waive the right to the above noted benefits under the PEBT Benefits Program. I understand that proof of insurability may be required if I wish to apply for these benefits at a later date, and that I may be refused coverage at that time.

Plan Member/Employee Signature ____ Date Signed (yyyy/mm/dd) ______________________