Please return completed form to your
District Benefits Administrator.

BRITISH COLUMBIA
PUBLIC SCHOOL
EMPLOYERS' ASSOCIATION
SOLUTIONS AT WORK

Notice of Leave

Employee Information

Employee's Surname	First Name	Initial

District #:
Employee #:
Occupation:

Leave of Absence from: ______________________ to: ______________________

Is this an extension of a previous leave: ☐ Yes ☐ No

Reason for Leave: ______________________

Do you plan to leave the province during your leave? ☐ No ☐ Yes, from: ______________ to: ______________

If yes, destination(s): ______________________

Use back of form if destinations and dates do not fit in space provided. Please note that your provincial health plan must approve continuation of coverage for a leave of absence outside of the province exceeding six months. Coverage for extended health ceases the day you are no longer covered under your provincial health plan.

Please indicate the applicable benefits to be continued during your leave of absence and the current level of coverage:

		Current level of coverage	**Insurer Approval**	
☐ Basic Life Insurance		______________	Approved	Declined
☐ Optional Life Insurance	☐ Employee:	______________	Approved	Declined
	☐ Spouse:	______________		
	☐ Child:	______________		
☐ Basic Accident Insurance		______________	Approved	Declined
☐ Optional Accident Insurance		______________	Approved	Declined
☐ Extended Health (please circle):		Single Couple Family	Approved	Declined
☐ Dental Care (please circle):		Single Couple Family	Approved	Declined
☐ Short Term Disability		______________	Approved	Declined
☐ Long Term Disability (if insured by Pacific Blue Cross)		______________	Approved	Declined

Please note that long term disability (LTD) can be continued through Maternity, Parental and EI Compassionate leave. Approval is required for other types of leave.

Benefits will continue through Maternity Leave, Parental Leave and EI Compassionate Care Leave. However, should you not wish to continue to pay your share of premium contribution for benefits during these leave of absences, your District is not required to pay your portion of the premium and continue coverage on your behalf. Please check with your Benefits Administrator regarding continuation of coverage policies specific to your district in these circumstances. For any benefits shown above that you have chosen not to continue, you are waiving your rights to these benefits until you return from your leave of absence. If you are eligible to continue LTD coverage but choose not to, any disability that occurs during your leave of absence will not be covered by the LTD policy.

Please note that cost sharing arrangements may be different while on a leave of absence for leaves other than Maternity, Parental and EI Compassionate leave. Please check with your Benefits Administrator for cost sharing information. Your District Benefits Administrator will inform you how long coverage for each benefit will be continued while you are on a leave of absence.

I certify that I understand the above and have been informed by the District's Benefits Administrator of the coverage available to me during my leave of absence.

Employee Signature: ______________________ Date Signed: ______________________

Benefits Administrator, please fax this form to Pacific Blue Cross: 604-419-2149 or email to enrolment@pac.bluecross.ca
AIG Insurance Company of Canada – 1-800-387-4481 or email aigcanada.ah@aig.com