# The MEARIE Group Employee Benefit Program REQUEST FOR BENEFIT CONTINUATION FORM (LOA/Lay-Off)

**THE MEARIE GROUP USE ONLY**

Insurer ______ Policy No. ______

## SECTION 1: Plan Member Information

| Employer Name | |
|---|---|
| Division Number | Class Number |
| Plan Member ID | Payroll ID (if applicable) |
| Plan Member Name<br>FIRST NAME | LAST NAME |
| Date of Hire (MM/DD/YYYY): | First Day of LOA/Lay-Off (MM/DD/YYYY): |
| Expected Return to Work Date from LOA/Lay-Off (MM/DD/YYYY): | Is the Member disabled? ☐ Yes ☐ No |
| Reason for the LOA/Lay-Off, reason for the leave and where the Member will be located during the leave. | |

## SECTION 2: Benefit Continuation Request

Please indicate ONLY those benefits to be continued (if applicable) and the last date of coverage. Note: benefits not listed below will be discontinued on the first day of LOA/Lay-Off. Benefit continuances during a period of LOA/Lay-Off should be managed in accordance with your employment policies and practices, but in no event may STD/LTD be continued more than 31 days after the date the LOA/Lay-Off begins or more than 6 months after the date the LOA/Lay-Off begins for all other benefits. If the continuance period you are requesting extends beyond these periods permitted under the policy, prior approval from the insurer is required.

| BENEFIT | BENEFIT AMOUNT | | LAST DAY OF COVERAGE REQUESTED (MM/DD/YYYY) |
|---|---|---|---|
| ☐ Basic Term Life insurance | | | |
| ☐ Basic Life Insurance | | | |
| ☐ Supplemental and Optional Life Insurance | | | |
| ☐ AD&D Insurance | | | |
| ☐ Long-Term Disability | | | |
| ☐ Short-Term Disability | | | |
| ☐ Health | ☐ Single | ☐ Family | |
| ☐ Dental | ☐ Single | ☐ Family | |
| ☐ Employee Assistance Program (EAP) | | | |
| ☐ Best Doctors | | | |
| ☐ Healthcare Spending Account | | | |
| ☐ Critical Illness | | | |
| ☐ Other (Please specify) | | | |

## SECTION 3: Plan Administrator Authorization (no signature required)

☐ As the plan administrator, I authorize The MEARIE Group to process the changes noted above.

| Plan Administrator Name (Signature) | Date (MM/DD/YYYY) |
|---|---|
| | |

**The Plan Administrator is responsible for the following:**

1. Obtaining legal advice regarding termination of employment and continuation of benefits, if applicable,
2. Collecting any required plan member premium contributions for the benefits to be continued, as applicable,
3. Advising The MEARIE Group if, subsequent to the approval of continuation of benefits, coverage should cease earlier than requested; and,
4. Informing the plan member of the terms and conditions under which coverage is being continued.