

**SUSPENSION OF BENEFITS
OPSEU**

**TO: Simcoe County District School Board
Benefits
Payroll Department**

I _____ I.D. # _____

Would like to suspend the following benefits for the duration of my leave of absence.

BENEFIT	INITIALS
Dental Health	_____
Extended Health	_____
Life Insurance	_____
Dependent Life Insurance	_____
Long Term Disability	_____

Effective date for start of leave: _____

Effective date for expiration of leave: _____

Effective date for suspension of benefits: _____

Please notify Payroll Department if you return to work earlier than your expiration of leave date.

By signing this form you are acknowledging the following:

- 1) The suspension of the above initialed benefits will be for the entire duration of your leave. Benefits cannot be reinstated, at any time, during your leave.
- 2) You are not eligible, at any time, to make claims on the suspended benefits for costs incurred during your leave of absence.
- 3) If you return to work within 12 months following the start date of your leave, your coverage may be reinstated on the date you return to work.

SIGNATURE: _____

DATE: _____