Chambers Plan
Employee Benefits

JG11-CH

Employee Reinstatement Request

TO BE COMPLETED BY THE EMPLOYER

Company Name _____ Firm # _____

Employee Name _____ Certificate # _____

Plan Administrator's Name _____

Plan Administrator's Signature _____ Date _____

REINSTATE EMPLOYEE'S COVERAGE

Left Employment/ Leave of Absence/ Temporary Lay Off

Coverage may be reinstated provided the individual returns within six (6) months of the termination date and we are notified in writing within thirty-one (31) days of their return date. Coverage is effective on the first day of the month following the date of return, not the date of notification.

❑ Reinstate ALL Coverage Date of Return (YYYY/MM/DD) _____

Medical Leave

Coverage may be reinstated provided the individual returns within six (6) months, a Record of Employment (ROE) is provided, and we are notified within thirty-one (31) days of their return. Coverage is effective on the first of the month following the date of return, not the date of notification. Please include the ROE.

If an ROE is not provided, the employee is considered a "Late Entrant". Medical evidence of insurability will be required. If approved, coverage begins first of the month following the date the application is approved by the insurer. Please include *Employee Statement of Health* and *Dependent Statement of Health* forms.

❑ Return from Medical Leave Date of Return (YYYY/MM/DD) _____

Maternity/ Parental Leave

When returning from maternity/parental leave, coverage may be reinstated provided the individual returns within the province's legislated maternity/parental leave period and we are notified in writing within thirty-one (31) days of their return date. Coverage is effective on the first day of the month following the date of return, not the date of notification.

❑ Return from Maternity/Parental Leave Date of Return (YYYY/MM/DD) _____

If returning from maternity/parental leave, please complete dependent and coverage information, if applicable.

SPOUSE/DEPENDENT INFORMATION

	First Name	Last Name	Birthdate (YYYY/MM/DD)	Sex (M/F)	Full-Time Student (age 21-25)	Disabled Dependent (age 21 & over)
❑ Add ❑ Delete Spouse					❑	❑
❑ Add ❑ Son ❑ Delete ❑ Daughter					❑	❑
❑ Add ❑ Son ❑ Delete ❑ Daughter					❑	❑
❑ Add ❑ Son ❑ Delete ❑ Daughter					❑	❑

I understand that I, and my dependents, must be covered under my Provincial Health plan in order to be eligible for Extended Health coverage.

For employee changes, please refer to the *Employee Change Request* form found at www.chambersplan.ca or www.mybenefits.ca.