Health Benefits Administration
Employee on Leave of Absence
Waiver of Coverage

I acknowledge that I took into consideration the Health Benefits Plan and have decided to opt out of the following benefits:

- Life insurance
- Dependent Life Insurance
- Accidental Death and Dismemberment insurance (AD&D)
- Optional Benefits
- Short Term Disability
- Long Term Disability
- Health Care Benefits (incl. Travel)
- Vision Care Benefits
- Dental Care Benefits

I am aware that if my leave of absence is a maternity/parental/paternity leave, I have three (3) choices for benefit coverage during my leave and must make my decision prior to my absence:

1. Continue all benefit coverage
2. Opt-out of all benefit coverage
3. Continue all benefit coverage, except disability coverage

I will not hold the _____ Conference of the Seventh-day Adventist Church responsible should any of these services be required by me or any of my dependents and I understand that I am not covered by any of the services offered under the Health Benefits Plan that I was eligible to participate in prior to the signing of this waiver.

I hereby declare that I willingly, on my own accord, by signing the document do so choose to opt out of the Health Benefits Plan that the _____ Conference offers to all employees who work .50% FTE or higher. I understand that I will not have health benefits coverage under the Health Benefits Plan of the Seventh-day Adventist Church in Canada during the requested leave of absence from _____ through to _____.

Employee Name	Employee Signature	Date:
Witness Name	Witness Signature	Date:
Employer Name	Employer Signature	Date: