Application for Continuation of Group Benefits while on a Leave of Absence

Employee's Name _____

Employee's E-mail Address:_____

Employee Telephone Number _____

RF Employee Number _____

Campus Location _____

Continuation period: From: _____To_____:

I elect to continue <u>ALL</u> benefits which I am currently enrolled in as indicated below:

*Below, please indicate the benefits you are currently enrolled in. This is **not** an opportunity to modify your current benefits enrollment.*

_____ **Health Insurance**

The employee share of the biweekly premium must be paid for continuation of Health Insurance

_____ **Dental Insurance**

The employee share of the biweekly premium must be paid for continuation of Dental Insurance

_____ **Vision Insurance**

The employee share of the biweekly premium must be paid for continuation of Vision Insurance

_____ **Optional Life Insurance**

Optional Life Insurance continuation requires payment of the employee premium

_____ **Dependent Optional Life**

Dependent Optional Life Insurance continuation requires payment of the employee premium

_____ **Voluntary Short-Term Disability Insurance**

Voluntary Short-Term Disability Insurance continuation requires payment of the employee premium

_____ **Paid Family Leave**

Paid Family Leave regulations require payment of the required employee premiums

I hereby authorize The Research Foundation for SUNY to bill me for the biweekly cost of the above selected benefits for continuation of my benefits until the total amount owed has been fully paid.

Signature: _____ Date: _____

March, 2020