APPLICATION FOR WAIVER OF GROUP LIFE INSURANCE PREMIUM PAYMENTS
C0-819 Rev. 12/2019

THE COMPLETED APPLICATION MUST BE SUBMITTED TO THE OFFICE OF THE STATE COMPTROLLER, RETIREMENT & BENEFIT SERVICES DIVISION, GROUP LIFE UNIT, 165 CAPITOL AVENUE, HARTFORD, CT 06106 **WITHIN TWELVE (12) MONTHS FROM THE EMPLOYEE'S LAST DAY ACTIVELY AT WORK.**

PREMIUM WAIVER POLICY AND QUALIFICATIONS:

- MUST BE CURRENTLY ENROLLED IN THE GROUP LIFE INSURANCE PLAN.
- MUST BE TOTALLY AND PERMANENTLY DISABLED FROM PERFORMING ANY GAINFUL OR REASONABLE WORK FOR A MINIMUM OF NINE MONTHS.
- UNDER SIXTY (60) YEARS OF AGE ON THE LAST DAY PRESENT AND WORKING.
- DETERMINATION FOR WAIVER OF INSURANCE PREMIUM IS MADE NO EARLIER THAN NINE (9) MONTHS AFTER THE LAST DAY PRESENT AND WORKING.
- PREMIUM PAYMENTS MUST BE MADE FOR THIS ENTIRE NINE MONTH PERIOD AND UNTIL A DECISION IS RENDERED BY THE INSURANCE CARRIER, WHICHEVER IS GREATER.

SUBMIT APPLICATION UNDER ANY ONE OF THE FOLLOWING CONDITIONS:

1. WHEN ON LEAVE OF ABSENCE DUE TO PERMANENT AND TOTAL DISABILITY FOR A PERIOD OF 9 MONTHS.
2. WHEN PLANNING TO RETIRE DUE TO PERMANENT AND TOTAL DISABILITY.

SECTION I. TO BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME (Last, First. Middle Initial)	EMPLOYEE I. D. NUMBER	SOCIAL SECURITY NUMBER
HOME ADDRESS (Street No., Name, City, Zip Code)	DATE OF BIRTH	HOME TELEPHONE NUMBER

I WISH TO APPLY FOR A WAIVER OF GROUP LIFE INSURANCE PREMIUMS. I UNDERSTAND THAT I MUST CONTINUE TO PAY THE MONTHLY PREMIUM UNTIL A DECISION IS RENDERED BY THE INSURANCE COMPANY REGARDING MY WAIVER APPLICATION OR FOR NINE MONTHS, WHICHEVER IS GREATER. PAYMENTS MUST BE SENT IN MONTHLY TO MY AGENCY HUMAN RESOURCE/PAYROLL OFFICE. I UNDERSTAND THAT COVERAGE MAY BE TERMINATED FOR NON-PAYMENT OF PREMIUM IF I FAIL TO MAKE THE PREMIUM PAYMENTS. I ALSO UNDERSTAND THAT I MUST NOTIFY THE OFFICE OF THE STATE COMPTROLLER IF I RECOVER AND TOTAL AND PERMANENT DISABILITY SHOULD CEASE.

EMPLOYEE SIGNATURE	DATE

SECTION II. TO BE COMPLETED BY AGENCY

AGENCY NAME and ADDRESS	AGENCY TELEPHONE NUMBER	DEPARTMENT I. D.

INDICATE LAST DAY EMPLOYEE WAS PRESENT AND WORKING:

INDICATE LAST DAY PREMIUMS ARE PAID THROUGH:

IS EMPLOYEE ENROLLED IN BENEFITS BILLING? ☐ Y ☐ N

EMPLOYEE ANNUAL SALARY (AS OF LAST DAY WORKED): $

AMOUNT OF BASIC GROUP LIFE INSURANCE: $

HAS EMPLOYEE APPLIED FOR WORKER'S COMPENSATION?	IS EMPLOYEE RECEIVING WORKER'S COMPENSATION?	IF YES, EFFECTIVE DATE:
☐ Y ☐ N	☐ Y ☐ N	

IS EMPLOYEE ON LEAVE OF ABSENCE DUE TO PERMANENT AND TOTAL DISABILITY ? ☐ Y ☐ N — IF YES, EFFECTIVE DATE :

IS EMPLOYEE RETIRED DUE TO DISABILITY? ☐ Y ☐ N — IF YES, EFFECTIVE DATE :

AUTHORIZED AGENCY SIGNATURE	DATE

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