



ANNE ARUNDEL COUNTY PUBLIC SCHOOLS

Memo

To: Employees on Leave of Absence

Date

File Code

From: Susan Baugher  
Benefits Manager

Instructions:

**You Must Respond Within  
30 Days Of Notification**

Subject: **Continuation of Group Health &  
Voluntary Life Insurance Benefits**

Copies to:

Anne Arundel County Public Schools (AACPS) permits employees on a leave of absence (LOA) without pay to continue their group healthcare and voluntary life insurance by paying the full monthly premium payment. If you wish to continue your benefits, please contact HR Benefits at 410-222-5221 to verify premium amounts. **Due to Maryland State law, coverage cannot be terminated retroactively, therefore payment is due by the 20<sup>th</sup> of the month prior. For example, payment for April is due no later than March 20<sup>th</sup>.** Failure to remit on a timely basis will result in immediate termination of your health care benefits. Your active status health care has been terminated. You must complete and return this form, with your payment, to activate health care under the LOA provisions.

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**PLEASE COMPLETE BELOW AND RETURN WITH YOUR CHECK**

To: Anne Arundel County Public Schools  
2644 Riva Road  
Annapolis, MD 21401

Attn: Ms. Vickie Stevenson  
HR Benefits

Name \_\_\_\_\_  
Number \_\_\_\_\_  
(please print)

Social Security

Address \_\_\_\_\_  
Number \_\_\_\_\_

Phone

Leave of Absence Dates From: \_\_\_\_\_ To \_\_\_\_\_

Is LOA due to a work related injury? Yes \_\_\_ No \_\_\_

**Please confirm your election to continue/not continue your coverages below:**

\_\_\_ **I wish to continue the following benefits while I am on LOA.** I understand the full premium is due by the **20<sup>th</sup> of the month prior** (for example April payment due March 20<sup>th</sup>) and I understand that late or non-payment will result in immediate cancellation of my insurance. If I terminate employment while on LOA, I understand I have 31 days to contact HR Benefits to apply to extend my health insurance through COBRA continuation of benefits.

| Indicate Type of Coverage<br>(Traditional, PPN, Aetna, Bluechoice, etc.) | Indicate Level of Coverage<br>(Ind, Parent/Child, Husband/Wife,<br>Family) | Monthly or<br>Bi-Weekly<br>Premium |
|--|--|------------------------------------|
| Medical  |  |                                    |
| Dental   |  |                                    |
| Vision   |  |                                    |
| Voluntary Life   |  |                                    |
| <b>Total</b>   |  |                                    |

\_\_\_ **I will not continue benefits during my LOA and I understand that I must re-apply for benefits upon my return to active status.**