PUBLIC SERVICE GROUP INSURANCE FUND
WAIVER OF GROUP INSURANCE DURING AN EMPLOYER APPROVED LEAVE OF ABSENCE OR LAY-OFF

PERSONAL INFORMATION (to be answered in full by employee, please print or type)

Name of Employee _____
(Last Name) **(Given Names in Full)**

Employee Number _____ **Employer** _____

I acknowledge that I do not wish to continue to be insured during my period of employer approved leave of absence/lay-off from

_____ **to** _____.
Date **Date**

_____ _____
Signature of Insured Member **Date**

_____ _____
Witness to the Above Signature **Date**

SEND ORIGINAL SIGNED COPY TO PAYROLL/HUMAN RESOURCES DEPARTMENT