EMPLOYEE FUNDED LEAVE PROGRAM

PROGRAM APPLICATION

EMPLOYEE INFORMATION

Name _____ **Social Insurance Number** | | | | | | | | | |
last name first name initial

Address _____
suite no. street/box no.

_____
city province postal code

For Office Use Only.

Employee Number | | | | | | | |

Ministry |

Birthdate | | | | | | Gender |
Y / M / D

APPLICATION

1. I wish to begin my deferral period on _____ pay day.
(First pay day following the approval.)

2. I wish to begin my Leave of Absence on the first day of _____.

3. The length of my Leave of Absence will be _____ months (6 to 12 full calendar months).

4. The amount I wish to defer is $_____ per pay period.
(Cannot exceed 33 1/3% and cannot be less than 10% of basic gross monthly salary.)

5. I hereby designate _____ _____ as my revokable beneficiary.
name in full relationship to employee

6. I have read the information provided on the ***Employee Funded Leave Program*** and understand the terms and provisions of this program.

_____ _____
(Date) (Employee's Signature)

MINISTRY APPROVAL

This application is _____ (approved/denied).

_____ _____
(Date) (Deputy Head or designate)