EMPLOYEE FUNDED LEAVE PROGRAM

CHANGE REQUEST

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 | | | | | | | |

Department | |

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

CHANGE REQUEST

1. Effective _____ I wish to change my deferral amount to $_____.
(pay day)
(May be changed <u>once</u> per calendar year. Cannot exceed 33 1/3% and cannot be less than 10% of basic gross monthly salary.)

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

3. I wish to change the length of my Leave of Absence to _____ months (6 to 12 full calendar months).

4. Effective _____ I hereby revoke any previous beneficiary and appoint
_____ _____ as my revokable beneficiary.
(name in full) (relationship to employee)

5. 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)

DEPARTMENTAL APPROVAL

This change is _____ (approved/denied).

_____ _____
(Date) (Deputy Minister or Chief Executive Officer)