EMPLOYEE FUNDED LEAVE PROGRAM

BENEFIT PAYMENT AUTHORIZATION AND DIRECTION

EMPLOYEE INFORMATION

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

Address _____
suite no. street/box no.

_____
city province postal code

TYPE OF PAYMENT

I request that payment be made:

☐ Monthly starting _____ for _____ months.
month year number

☐ One Lump Sum Payment payable _____.
month year

☐ Two Equal Payments payable _____ and
month year

_____.
month year

Note: *Unless the information for the Direct Deposit Request is completed below, the payment cheque(s) will be mailed to your home address.*

DIRECT DEPOSIT REQUEST

Name of Financial Institution _____

Address of Financial Institution _____

A voided personal cheque or bank certification of Branch, Bank and Account Numbers must be provided to ensure the accuracy of the information.

EMPLOYEE'S AUTHORIZATION

_____ _____
Date Employee's Signature

FOR CHR USE ONLY

This is sufficient information, authority and direction to make payment from the fund as directed above. This direction is in accordance with the terms and conditions of the Plan and Trust Agreement governing such payment.

_____
(Authorized Signature)