PREPAID LEAVE PLAN

**APPLICATION**

**EMPLOYEE NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPL. ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DEPT./CENTRE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Academic**

**□ Administrative**

**□ Support**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Payroll Deduction: (max. of 5 year deferral) Leave of Absence:**

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Start Date End Date Start Date End Date

**Salary Deferral Arrangements:**

□ one year deferral of up to 1/2 annual regular salary (50% - see note below)

□ two years deferral of up to 1/3 annual regular salary (33.33%)

□ three year deferral of up to 1/4 annual regular salary (25%)

□ four year deferral of up to 1/5 annual regular salary (20%)

□ five year deferral of up to 1/6 annual regular salary (16.66%)

NOTE: The percent and amount of monies being deferred during the deferral period cannot exceed the ratio of the period of the leave of absence (measured in months) divided by the total period of participation in the Prepaid Leave Plan. (Example: 48 month deferral, 12 month LOA = 12/(48 + 12) x 100 = 20% maximum deferral percentage).

In addition, under no circumstances can deferred salary exceed CCRA's maximum of 33-1/3% in any calendar year.

**Employee Certification:**

1. I have read the information provided on the PREPAID LEAVE PLAN and understand and agree to the terms and conditions of this plan.

2. I authorize my employer to deduct from my salary the amount set out in this application and to deposit these amounts in an interest bearing account, with interest calculated monthly in accordance with applicable Collective Agreements and Terms & Conditions of Employment.

3. I agree that my employer is not liable for, and is released from, any and all claims which arise, directly or indirectly, in connection with this Plan.

4. I authorize the pay-out of any/all functions to the below named beneficiary in the event of death.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature Date

**DESIGNATED BENEFICIARY:**

Beneficiary Surname First Name Initial Relationship to Employee

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_