

## DEFERRED SALARY LEAVE PROGRAM CHANGE / CANCELLATION REQUEST

**INSTRUCTIONS:**

- This form is used to change the terms of agreement or to cancel the Deferred Salary Leave Program.
- Please allow **60 calendar days** for processing changes to this application.
- For further information, contact the Benefits Service Centre toll-free at 1 877 277-0772.
- Information is also available on these Internets:  
[www.bcpublicservice.ca/benefits](http://www.bcpublicservice.ca/benefits), [www.icbcweb](http://www.icbcweb),  
and [www.homeweb.bchmc.bc.ca](http://www.homeweb.bchmc.bc.ca)

**Freedom of Information and Protection of Privacy Act (FOIPPA)** – The personal information requested on this form is collected for the purpose of administering the *Public Service Benefit Plan Act* and is in accordance with the *FOIPPA*. Questions about the use and collection of this information can be directed to the FOI Designate at 250 544-5400, or toll-free at 1 877 277-0772, Telus Sourcing Solutions, Block E, 2261 Keating Cross Road, Saanichton BC V8M 2A5.

**PLEASE TYPE OR PRINT CLEARLY**

**PART A – EMPLOYEE INFORMATION**

EMPLOYEE LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL INSURANCE NO.
EMPLOYEE HOME ADDRESS – <i>INCLUDE PO BOX NO.</i>		CITY	PROVINCE
MINISTRY / EMPLOYER NAME		DEPARTMENT ID	EMPLOYEE ID
		-	UNION CODE

**PART B – TYPE OF REQUEST**

**1. CHANGE** *Complete this section for a change to terms of the Deferred Salary Leave Program.*

Note: Leave period is a minimum 6, maximum 12 continuous months.

APPROVED START DATE YYYY / MM / DD	APPROVED END DATE YYYY / MM / DD	PROPOSED NEW START DATE YYYY / MM / DD	PROPOSED NEW END DATE YYYY / MM / DD
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BI - WEEKLY DEFERRED AMOUNT Cannot exceed 33 1/3% or be less than 10% of gross bi - weekly salary	%	INVESTMENT OPTIONS <i>GUARANTEED INVESTMENT CERTIFICATE</i> Indicate percentage of deferred amount	%	SAVINGS ACCOUNT Indicate percentage of deferred amount	%
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BENEFICIARY SURNAME	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP TO EMPLOYEE
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**2. CANCELLATION** *Complete this section for cancellation of the Deferred Salary Leave Program.*

CANCELLATION DATE YYYY / MM / DD	I understand that by withdrawing from the program, the funds held by the financial institution on my behalf will be paid out in full, in a timely manner, within this calendar year, and I have obtained such independent legal and/or tax advice in this regard as I deemed necessary. I wish to withdraw from the Deferred Salary Leave Program for the following reason:
	<input type="checkbox"/> FINANCIAL HARDSHIP <input type="checkbox"/> OTHER: _____

**PART C – EMPLOYEE CERTIFICATION**

- I have read the information provided on the DEFERRED SALARY LEAVE PROGRAM and understand and agree to the terms and provisions of this program.
- I understand that if monies transferred to my account are inaccurate, the funds can be recovered.
- I assume responsibility for the tracking and reconciling of funds deposited to my account.
- I authorize the payment of any / all funds to my named beneficiary in the event of death.

EMPLOYEE SIGNATURE ➤	DATE SIGNED YYYY    MM    DD
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**PART D – MINISTRY / EMPLOYER CERTIFICATION**

DIRECTOR / EQUIVALENT SIGNATURE	DATE SIGNED YYYY    MM    DD
<input type="checkbox"/> RECOMMEND EMPLOYEE <input type="checkbox"/> DO NOT RECOMMEND EMPLOYEE AT THIS TIME ➤	
APPROVING AUTHORITY SIGNATURE Approval for the employee to change the terms of the agreement or to cancel the Deferred Salary Leave Program is:	DATE SIGNED YYYY    MM    DD
<input type="checkbox"/> GRANTED <input type="checkbox"/> DENIED ➤	

**PART E – PAY OFFICE USE ONLY**

CHANGE DEDUCTION END DATE TO PRIOR PAY PERIOD	PAY OFFICE CONTACT NAME – <i>Please type or print clearly</i>	CONTACT PHONE NO. (    )
NEW CHIPS EFFECTIVE DATE YYYY    MM    DD	NEW DEDUCTION END DATE YYYY    MM    DD	<b>FORWARD ORIGINAL TO:</b> Group Retirement Services 1101 – 734 7 Avenue SW Calgary, Alberta T2P 3P8 Fax No: 403 531-1477
ENTERED INTO CHIPS BY	DATE ENTERED YYYY    MM    DD	