BRITISH COLUMBIA
BC Public Service

Where ideas work

DEFERRED SALARY LEAVE PROGRAM
CHANGE / CANCELLATION REQUEST FORM

INSTRUCTIONS:

- Complete Parts A, B and C and have your employer complete Part D. (The start date for any changes to your bi-weekly deferred amount must be at least 60 calendar days in the future to allow time for processing the form.)
- BC Public Service employees must send the completed form to Payroll via an AskMyHR Service Request **www.gov.bc.ca/myhr/contact**. Participants working for other employers must send the completed form to their Human Resources Office.
- All applicants MUST also fax or mail a copy to Group Retirement Services. Fax: 1-888-797-0071
  Mail: Group Retirement Services, 255 Dufferin Avenue, London, ON, N6A 4K1.
- Information is available at **www.gov.bc.ca/myhr**. If you have any questions, please call 1-877-277-0772.

Freedom of Information and Protection of Privacy Act (FOIPPA)
This information is collected by the British Columbia Public Service under s. 26(c) of FOIPPA. Any questions about the collection and the use of this information can be directed to an HR Service Representative at the BC Public Service Agency by submitting a request to AskMyHR and selecting My Team/Organization > Employee & Labour Relations > Other Issues & Inquiries, phoning: 1-877-277-0772 or writing to: Manager, Contact Centre Operations, BC Public Service Agency, 810 Blanshard Street, Victoria, BC V8W 2H2.

PLEASE TYPE OR PRINT CLEARLY

PART A – EMPLOYEE INFORMATION

EMPLOYEE LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE (YYYY/MM/DD)	SOCIAL INSURANCE NO.

EMPLOYEE HOME ADDRESS – *Include PO BOX, if applicable)*	CITY, PROVINCE	POSTAL CODE	PHONE NUMBER

MINISTRY / EMPLOYER NAME	DEPARTMENT ID	EMPLOYEE ID	UNION CODE	EMAIL
	–			

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.

CURRENT LEAVE START DATE YYYY / MM / DD	**CURRENT** LEAVE END DATE YYYY / MM / DD	**PROPOSED NEW** LEAVE START DATE YYYY / MM / DD	**PROPOSED NEW** LEAVE END DATE YYYY / MM / DD

BI - WEEKLY DEFERRED AMOUNT	INVESTMENT OPTIONS		*SAVINGS ACCOUNT*	
Cannot exceed 33 1/3% or be less than 10% of gross bi - weekly salary				
%	*GUARANTEED INVESTMENT CERTIFICATE* Indicate percentage of deferred amount	%	Indicate percentage of deferred amount	%

BENEFICIARY'S LAST NAME	FIRST NAME & MIDDLE INITIAL	RELATIONSHIP TO YOU	CONTACT EMAIL OR PHONE NUMBER

☐ **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:

☐ FINANCIAL HARDSHIP ☐ OTHER: _____

DIRECT DEPOSIT AUTHORIZATION (To have lump sum payment deposited into your bank account.)
CHEQUING ACCOUNT - attach a personal encoded deposit slip or a voided cheque
SAVINGS ACCOUNT - take this form to your bank/credit union/trust company for verification

BRANCH ID	**INSTITUTION**	**ACCOUNT NUMBER**

BANK OR FINANCIAL INSTITUTION VERIFICATION Not required if encoded cheque or deposit slip attached. Signature or bank stamp confirming accuracy of transit and account number and authenticity of account signature. ▶

BANK OR FINANCIAL INSTITUTION ADDRESS

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. The change in my deferral period does not exceed the maximum of 6 years from my original application and my leave commences immediately following the end of my deferral period and the duration of my leave period is within a minimum of 6 months to a maximum of 12 months.
- 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

PART D – MINISTRY / EMPLOYER CERTIFICATION

DIRECTOR or EQUIVALENT SIGNATURE ☐ RECOMMEND EMPLOYEE ☐ DO NOT RECOMMEND ▶ DATE SIGNED YYYY MM DD

APPROVING AUTHORITY SIGNATURE
Approval for the employee to change the terms of the agreement or to cancel the Deferred Salary Leave Program is: ☐ GRANTED ☐ DENIED ▶ DATE SIGNED YYYY MM DD

PART E – PAY OFFICE USE ONLY

CHANGE DEDUCTION END DATE TO PRIOR PAY PERIOD YYYY MM DD		PAY OFFICE CONTACT NAME	PHONE NO. ( )

NEW CHIPS EFFECTIVE DATE YYYY MM DD	NEW DEDUCTION END DATE YYYY MM DD	ENTERED INTO CHIPS BY	DATE ENTERED YYYY MM DD

Clear Form