

SUPPLEMENTARY EMPLOYMENT BENEFITS CLAIM/UNDERSTANDING

Date: _____

To: Human Resources

From: _____ (Claimant)

This will advise you that I am in receipt of Employment Insurance benefits and therefore eligible for Pregnancy Leave with Supplementary Employment Benefits with NSCAD University.

In consideration of the foregoing, I hereby undertake:

1. to return to work following the conclusion of my leave, or any authorized extension thereof, and
2. to remain in the employ of the college for a period of at least seventeen (17) weeks from that date.

If these two conditions are not met, I understand and agree that the College, at its option, may require me to repay, in the first instance

1. the full amount of Supplementary Employment Benefits received during the entire period of my leave, and in the second instance
2. a proportion of such benefits equal to that proportion of the seventeen (17) week period which I have not worked.

Claimant's Signature

Responsible Manager

Date of Claim

Date of Approval

Please attach original approved copy of this form to the Staff Report Form.