ELCIC Group Services Inc.

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CONTINUING EDUCATION PLAN (CEP) ENROLLMENT FORM

Member Information:										
Name:	Last		First	First		Member Number: (if known)				
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Beneficiary Appointment										
Must be a Canadian resident at time of payment, otherwise benefit amount will be paid to member estate.										
Last Name First Name		First Name	Birth Date: (d/m/y) (If minor, complete Trustee Appointment)	Address (If different from member)	Relatio	onship	S.I.N.		% Share*	
								*		
If more space is required, provide information on reverse. * (Must equal 100%) Trustee Appointment for Minors										
First, Initial, Last Name Relationship Address										
If living, shall be and is hereby appointed trustee to receive and disburse any monies payable hereunder to such child(ren) aforesaid during minority, or failing such trustee, to the duly appointed guardian of such minor child(ren) as trustee. Payment so made to said trustee shall discharge the payer to the extent of such payment.										
Authorization Employee										
I certify that all information contained hereon is correct. I authorize my employer to deduct from my earnings the contributions required for the program. I consent to the information provided here being collected, used and disclosed by ELCIC Group Services Inc. (GSI) for purposes of activities related to the efficient administration of my entitlements under the continuing education plan. I consent to GSI disclosing and/or obtaining information to and from the Program Committee for Leadership in Ministry (PCLM).										
I understand that I have the right to access the personal information in my file, and if necessary, correct any inaccurate information.										
Employe	e's Signature	-		Date			Day M	Month	Year	
Authorization Employer										
I certify that will participate in the Continuing Education Plan as outlined in the CEP policy. We agree further to abide by the procedures for approving study leaves and to continue to pay our employee's salary and benefits during the short term leave and to arrange assistance during his/her absence.										
Employer Name						Employer Code				
Emplove	er's Signature				Date					
Tible of Cinner					_		Day M	Month	Year	
Title of S	oigner									