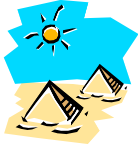
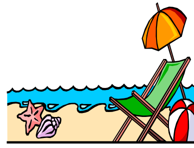
DISTRICT COUNCIL #4
HEALTH & WELFARE FUND
585 Aero Drive
Cheektowaga, NY 14225
Phone – (716) 565-0234
Fax – (716) 565-1494

VACATION FORM

NAME: ____

ADDRESS: ____

____

PHONE#: __________________Last 4 of SS#: __-__-__-__

TF Initial _________
Trustee Override
____

VACATION PERIOD:
(BENEFIT IS SIX WEEKS VACATION BETWEEN JUNE 1st AND MAY 31st)

BEGINNING DATE: ____________ENDING DATE: _____________

NUMBER OF WEEKS: ___________		Required in Account
$1435.62/WK. (JOURNEYMAN)	_________	$1600.00
$762.67/WK. (APPRENTICE)	_________	$850.00
$762.67/Wk. (INDUSTRIAL)	_________	$850.00

*****Please be sure to check the appropriate line, by signing this form you are taking responsibility for your choice!!*****

I HEREBY CERTIFY THAT I WILL BE ON VACATION AND REQUEST __________ WEEK(S) OF VACATION.

SIGNATURE: ___________________________________

DATE: ____________________________

IF YOU ARE COLLECTING UNEMPLOYMENT YOU MUST NOT BE COLLECTING VACATION PAY UNLESS YOU ARE CLAIMING IT TO THE DEPARTMENT OF LABOR PER NYS DOL!!!!

6/1/09