apta ATLANTIC PROVINCES TRUCKING ASSOCIATION

# APTA Charity Approval Committee

**Criteria for application:**

1. Applicant's earnings are the family's main source of income.
2. Applicant must be suffering from an illness or injury resulting in the inability to work more than 6 months.
3. Applicant must be an APTA member, APTA member employee or an APTA member's Owner Operator, in good standing for at least 12 months.
4. Applicant must be from Atlantic Canada.
5. Applicant must be an employee of the APTA member for more than 12 months.
6. Any award over 2 for APTA Member Company employee's in the same calendar year will be thoroughly evaluated and may be awarded at the Committee's discretion for exceptional circumstances.
7. A one-time award up to $5,000 may be allotted to the applicant at the Committee's discretion.

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Please provide the following information and submit to the APTA Executive Director.

105 Englehart Street, Suite 800
Dieppe, NB E1A 8K2
E-mail to: apta@apta.ca or Fax to: (506) 853-7424

Please note that this request must be made by an APTA member employer.

Prospective Recipient's Name: ______________________________

APTA Member, Employee or Owner Operator: ______________________________

Number of Years Employed in the Trucking Industry: ______________________________

Number of Years Employed with current APTA member: ______________________________

Employer's Name: ______________________________

Employer's Contact Information: ______________________________

Please provide your reason for this request including the cause of illness, last date worked, prognosis, expected date of return and any details you feel necessary for assessment.

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Your information will be distributed to all committee members for review. A response should be received within 10 working days. If you feel that the space allotted above is not adequate, please feel free to attach a separate sheet. Please complete the short questionnaire attached as it will assist us in the process and ensure that time delays are minimized.

## Questionnaire

Which of the following Group or Employer sponsored benefits is the member covered for?

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|---|---|---|
| Basic Life Insurance | Yes | No |
| Short Term Disability | Yes | No |
| Long Term Disability | Yes | No |
| Health Insurance | Yes | No |
| Critical Illness | Yes | No |

Signature of Submitter: ____________________________________________

Date Submitted: ____________________________________________