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 Fax (306) 787-5105
 Email SATCC@gov.sk.ca

APPRENTICESHIP TRAINING ALLOWANCE APPLICATION

1. CLIENT'S PSE NUMBER:

2. CLIENT'S FULL NAME:

3. CLIENT'S MAILING ADDRESS: PHONE: EMAIL:

street/box number city/town province postal code
 PHYSICAL ADDRESS (if different than mailing address above):

street/box number city/town postal code

4. PROGRAM/COURSE NAME:

LOCATION:

COURSE DATES:

Session #:

to

5. BANK INFORMATION (Electric Funds Transfer): Attach a VOID CHEQUE or provide BANKING INFORMATION as completed by your banking institution. If valid banking information does NOT exist, funds will be disbursed by cheque and mailed to the current mailing address on file.

6. Is your usual place of residence 50 km or more away from the training centre? Yes No

7. If yes, AND you will be maintaining a second residence, what will your COMPLETE TEMPORARY PHYSICAL ADDRESS be?

Phone

If you DO NOT have a temporary address at this time, it may be submitted at a later date by emailing SATCC@gov.sk.ca or calling 1-877-363-0536.

8. How many dependents live in your household with taxable income less than \$90 per week? _____

9. Have you already filed, or will be filing, an employment insurance claim to cover this period of training?

___ YES If yes, read the DECLARATION, sign/date and forward to the SATCC

___ NO If no, indicate the reason below

I am aware that I do not have enough insured weeks to qualify for employment insurance.

I have been self-employed for all or most of the past year.

Other, please explain

If you do not qualify for a new EI claim, you may be eligible for a training allowance as a "reachback" client if you:

- had an employment insurance claim which ended in the past 3 years; or

- have received maternity or parental benefits within the past 5 years.

Contact SATCC@gov.sk.ca for more information.

10. DECLARATION

I certify that the information given is true, correct, and complete in every aspect and I understand it may be subject to verification by Employment and Social Development Canada (ESDC) or its representative. I undertake to report to ESDC, as soon as possible, any changes in the above information. I am aware legal action can be taken against me for making false statements or failing to inform ESDC of changes to the information that would affect my entitlement to allowances and/or Employment Insurance Benefits. I agree that the information on this form may be shared with the authorities providing my training.

CLIENT SIGNATURE: X _____ Date: _____

For Office use Only: Allowance ? Yes ___ No ___ Comments: _____

LAFH ? Yes ___ No ___ Rate: Southern ___ Northern ___ Effective Date _____

LA ? Yes ___ No ___ # of Deps. _____ Effective Date _____

SUBMIT ATA FORM

Authorizing Signature: _____