SANTA CLARA
Valley Transportation Authority

MILITARY LEAVE
SUPPLEMENTAL SALARY AND HEALTH BENEFITS
ACKNOWLEDGEMENT AND AGREEMENT

Print Name _____

Employee I.D. Number _____ SSN _____

Home Phone _____ Work Phone _____

Job Title _____ Bargaining Unit _____

Work Location _____

Supervisor's Name _____ Supervisor's Phone _____

Military Leave Start Date _____

Anticipated End Date (if known) _____

Monthly Military Pay Rate (Including all cash allowances) _____

Name of Contact Person While on Active Duty _____

Contact Person's Daytime Phone _____

I, _____, certify that I meet the eligibility criteria for additional salary and health benefits for military leave related to terrorist activities or impending or actual armed conflict. I agree to provide copies of my military pay statements within 3 weeks after the end of each calendar quarter. I understand that if I fail to do so, future checks will be held until the information is provided.

I understand that health benefits are subject to the restrictions and limitations established by the health plans and that my dependents and I must meet all eligibility criteria and requirements of the health plans.

I agree to repay VTA in full for the supplemental salary and benefits if I do not return to work at VTA within 60 calendar days after the end of my active duty status. I understand I must remain employed for six months after I return to VTA, or I must re-pay the cost of supplemental salary and benefits in full.

Signature _____ Date _____