LEAVE OF ABSENCE (LOA) REQUEST FORM
Maternity & Parental

Please complete this form to request a leave under the CF Industries (the "Company") Paid Maternity and Parental Leave Policy for maternity and parental leaves. Provide the completed form to Human Resources **ninety (90) days** prior to the beginning of your scheduled leave date.

In order to participate in CF Industries' top-up for and parental leaves, please understand the following:

1. CF top-up maternity and parental leave benefits are only available as a result of birth or adoption of a child.
2. 2. Only full-time permanent personnel are eligible to access CF Industries top-up program provided they have:
   • Completed one (1) full year of active service with the Company.
   • Provided Human Resources with a copy of this form – completed and approved – at least ninety (90) days prior to your scheduled leave date.
3. The top-up (paid) portion of the leave provided by the Company must be used in full within six (6) consecutive months of birth or adoption.
4. First statement of EI earnings must be provided to Human Resources as soon as possible for top-up calculation.

Please complete the below fields to request a maternity or parental leave of absence

I, _____ (Employee Name), have read and understand the content and requirements of the Paid Maternity and Parental Leave Policy for parental and maternity leaves. I understand that my request for leave is subject to departmental/HR approval based on business needs.

Employee Name (Please Print)	
Employee ID	

Anticipated Start Date of Leave:	**Anticipated Date of Return to Work:**

Select your leave from one of the following options:

- ☐ **Maternity – Paid**
  (In conjunction with EI earnings, top-up to 100% up to 13 weeks.)
- ☐ **Parental – Paid**
  (In conjunction with EI earnings, top-up to 100% up to 2 weeks.)
- ☐ **Maternity/Parental – Unpaid**

Employee Signature:		*Date:*
Supervisor Approval:		*Date:*
Manager Approval:		*Date:*
HR Approval:		*Date:*
To Be Completed by HR (if not approved): **(Provide denial reason and initial).**		Date:_____

Employee Name (Please Print)	
Employee ID	

To Be Completed by HR for Payroll Processing:

Bi-Weekly Base Pay Amount (100%)	Bi-weekly EI Payment Amount	Bi-weekly Top Up Payment Amount

Coverage Start Date: **Coverage End Date:**

Provide sub-periods if required for payroll:

Week	Sub-period (added to comments)	Amount	Pay Date
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			