



# New Hire Employee Checklist

Savanna Well Servicing Inc.

Employee Legal Name		<input type="checkbox"/> New Hire
Position		<input type="checkbox"/> Referral
Location		<input type="checkbox"/> Rehire
<b>HR / Payroll / Benefits Documents</b>		<b>Check Box</b>
General Information Form (preferably NOT handwritten)		<input type="checkbox"/>
Recruitment Form		<input type="checkbox"/>
Your Three Rights as a Worker Acknowledgement Form		<input type="checkbox"/>
Energy Safety Canada Connect Access Permission Form		<input type="checkbox"/>
Signed Offer of Employment Letter		<input type="checkbox"/>
Direct Deposit Application Form		<input type="checkbox"/>
Direct Deposit Form From Banking Institution		<input type="checkbox"/>
Payroll Deduction Authorization Form		<input type="checkbox"/>
Personal Tax Credit Return - TD1 Federal		<input type="checkbox"/>
Personal Tax Credit Return - TD1 Provincial (AB Only)		<input type="checkbox"/>
TD4 Memo & TD4 Letter of Responsibility		<input type="checkbox"/>
Declaration of Exemption - TD4		<input type="checkbox"/>
Determination of Exemption - TD1-IN (if applicable)		<input type="checkbox"/>
Self-Identification Questionnaire (optional)		<input type="checkbox"/>
Group Benefits Application Form (Industrial Alliance)		<input type="checkbox"/>
Confidentiality Disclosure		<input type="checkbox"/>
Employee Policy Acknowledgement		<input type="checkbox"/>
Alcohol and Drug Policy Acknowledgement including Policy Highlights		<input type="checkbox"/>
Safety Boots Program Voucher Issued (if applicable)		<input type="checkbox"/>
Employee Stock Savings Plan Enrollment Form (SunLife - Optional)		<input type="checkbox"/>
Employee Referral Form (if Applicable)		<input type="checkbox"/>
<b>CAOEC or Internal Competency Book Given to the Employee</b>		
Greenhand <input type="checkbox"/>	Date Issued	Copy of Energy Safety Canada (or Enform) Competency certificate(s) given to Crew Coordinator (if applicable) <input type="checkbox"/>
Floorhand <input type="checkbox"/>	Date Issued	
Derrickhand <input type="checkbox"/>	Date Issued	
Operator <input type="checkbox"/>	Date Issued	
Copies of Safety Training Certificates (1 Per Page) [Example: H2S, First Aid, CSO, etc]		<input type="checkbox"/>
Fire Extinguisher Exam & Certificate		<input type="checkbox"/>
Hazard Recognition Online Certificate		<input type="checkbox"/>

<b>Proof of Completion (To be filled out by Orientation Facilitator)</b>	
Date Completed	
Facilitator Name	
Facilitator Signature	

Fill-in the section below. Please print clearly.



Savanna Well Servicing Inc.

## General Information Form – Field Employees

<b>Employee Legal Name</b>		<b>Rehire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Mailing Address</b>		<b>Postal Code</b>	
<b>City and Province</b>		<b>SIN</b>	
<b>Date of Birth</b> (DD / MMM / YYYY)		<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone (with area code)		<b>Cell Phone</b> (with area code)	
<b>E-mail Address</b>			
Health Care Card #		Province	
<b>Emergency Contact</b> Full Name		<b>Relationship to Employee</b>	
<b>Emergency Contact</b> Phone Number(s) with area code			
<b>Driver's License Number</b>		Province	
<b>Expiry Date</b> (DD / MMM / YYYY)		Class	
<b>Referral</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>--- The section below must be completed by HR ONLY ---</b>			
<b>Employee ID:</b>			
<b>Start Date:</b> (DD / MMM / YYYY)			
<b>Pay Rate:</b>			
<b>Benefits Eligibility:</b>	<input type="checkbox"/> Waived <input type="checkbox"/> 3 Month Wait		
<b>Position:</b>			
<b>Location &amp; Rig Number:</b>			
<b>Completed by:</b> (Type/Print Name of HR)			



# Recruitment Form

Savanna Well Servicing Inc.

NEW HIRE PERSONAL INFORMATION			
Full Name			
Are you a Canadian Citizen?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If not, are you legally able to work in Canada?	Yes <input type="checkbox"/> No <input type="checkbox"/>

REQUIRED INFORMATION: RELEVANT SERVICE RIG EXPERIENCE		
(Note: Indicate numbers of years of experience, if any, below)		
Industry Experience (Indicate No. of Years)		
Thermal Experience (Indicate No. of Years)		
Conventional Experience (Indicate No. of Years)		
Abandonment Experience (Indicate No. of Years)		
Enform Service Rig Competency?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, indicate level:

HOW DID YOU HEAR ABOUT SAVANNA:		
Have you previously been employed in any other division of Savanna former or current (e.g. Lakota, Western Lakota, Trailblazer, Akuna, Accell, Command Coil, Great Plains, D&D Oilfield Rentals, Cantool, Savanna Drilling, Savanna Well Servicing, Savanna Corporate, Chinook Drilling)?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, which Company?		When?
If no, how did you hear about us?	Industry/CAOEC <input type="checkbox"/> Media <input type="checkbox"/> Brochure <input type="checkbox"/> Referral <input type="checkbox"/> Website <input type="checkbox"/> Career Fair <input type="checkbox"/> Name of referrer: _____ Other (please explain): _____	



## Recruitment Form

Savanna Well Servicing Inc.

### PRE-PLACEMENT MEDICAL / FITNESS EVALUATION AND SUBSTANCE SCREENING

Savanna Well Servicing Inc. ("Savanna") believes in a substance free work place environment for the health and safety of all our employees. Also, an employee's ability to safely and efficiently carry out their job tasks is a critical element of the service we provide. Employment with our company is conditional to meeting the requirements/standards of our Pre-placement Medical/Fitness Evaluation and Substance Screening. The information that is obtained in the screening process will be maintained in a confidential manner. In the event that pre-placement medical testing is not completed prior to work placement, continued employment will be conditional on the completion of a medical/fitness and substance screening within a reasonable time frame.

Are you willing to submit to a Medical/Fitness Exam and Substance Screening? Yes ☐ No ☐

### EMPLOYMENT APPLICATION & DISCLOSURE STATEMENT

By signing below, the applicant is confirming that all information stated in their application or on his/her resume submitted in the application for employment is true and complete to the best of his/her knowledge. The applicant also confirms that there is no misleading or pertinent information deliberately left out that would lead to the appointment of a position with Savanna. **(Please initial here)** \_\_\_\_\_

As well, the applicant agrees he/she will be truthful and accurate and will not provide misleading or deliberately leave out pertinent information if he/she undergoes Savanna's pre-placement medical /fitness evaluation and substance screening process. **(Please initial here)** \_\_\_\_\_

The applicant understands that any false information, omission or misrepresentation provided on this application or during the pre-employment testing process is just cause for rejection of the application or, if employed, termination of employment for just cause. **(Please initial here)** \_\_\_\_\_

I also understand that if I am a successful applicant and become employed by Savanna that any pictures of me could be used for promotional purposes. **(Please initial here)** \_\_\_\_\_

Signature

Date

# Your Three Rights as a Worker

**Savanna One means we stop, speak up, and support each other. That starts with knowing your rights.**

At Savanna Well Servicing, we believe that every worker plays a critical role in creating and maintaining a safe work environment. Under Alberta's Occupational Health and Safety laws – and as part of the **Savanna One Standard** – you are not just allowed, but *expected*, to be actively involved in protecting your health and safety and that of those around you. Here's what that means:



## 1. Right to Know

You have the right to be informed about all hazards related to your job. Before you do any task, you must understand what could go wrong and how to protect yourself. We will provide you with the training, tools, and procedures you need. ***If you're unsure – ask.***



## 2. Right to Participate

You have the right – and the responsibility – to take part in health and safety decisions. This includes reporting hazards, taking part in safety meetings, inspections, and speaking with your Safety Rep. At Savanna, we're building a culture where everyone contributes, not just supervisors or safety personnel.



## 3. Right to Refuse Unsafe Work

You have the right to say **“STOP”** if you believe work is dangerous to you or others. If something doesn't feel right or safe, **DO NOT PROCEED**. Tell your supervisor immediately. We will follow a step-by-step process to review and resolve the issue. You will never be punished for refusing unsafe work if the process is followed properly.

### Savanna One is Our Standard

The *Savanna One Standard* means we plan, communicate, and act as one team. That includes:

- Stopping when things don't feel right
- Speaking up without fear
- Supporting each other to work safely, every time

These aren't just rights – they're part of our identity.  
**Know them. Use them. Expect them from others.**

☐

**Initial the adjacent box to confirm you understand your rights and commit to speaking up and using them when necessary.**



I, \_\_\_\_\_ (Please Print Name),  
candidate for consideration of employment with Savanna Well Servicing Inc. ("**Savanna**"), give  
consent to Designated Representatives from Savanna to disclose to Energy Safety Canada my  
personal information for the purpose of registering me in Energy Safety Canada courses.  
Personal information will consist of:

- I understand that I can obtain further information regarding Energy Safety Canada's privacy practices at <http://www.energysafetycanada.com/privacy.cfm> or by contacting the Energy Safety Canada's Privacy Officer at [privacy.officer@energysafetycanada.com](mailto:privacy.officer@energysafetycanada.com).

Date

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## Direct Deposit Application Form

<b>Employee's Full Name:</b>	<b>Social Insurance Number (SIN):</b>
<b>Employee's Home Address:</b>	
<b>Terms and Conditions:</b> <ul style="list-style-type: none"><li>• Your paycheck can be direct deposited to a banking institution of your choice.</li><li>• The Account <b>MUST</b> be in the employee's name.</li><li>• You may direct your pay into a single bank account only.</li><li>• If the VOID cheque or verified bank information is missing the employee's paycheck will be mailed to their home address on file.</li><li>• <b>We will not accept any hand written bank accounts!</b></li></ul>	
Attach VOID cheque or verified bank information here.	
<b>DECLARATION:</b> I hereby authorize Savanna Well Servicing Inc. ("Savanna") and/or subsidiaries to deposit my net pay to my account as noted above.	
<b>Employee Signature:</b>	<b>Date Signed:</b>

**Please complete and return to Payroll.**

# Payroll Deduction Authorization



<b>Employee's Full Name</b>	
<p>I acknowledge that during the course of my employment with Savanna Well Servicing Inc. ("Savanna" or "Company"), Savanna may incur costs relating to me for the following items that are not covered as part of my employment or for which I may receive a benefit outside of the workplace ("Deductible Costs"). I hereby authorize Savanna to deduct from my pay through payroll the actual cost to it of such Deductible Costs without prior notice to me:</p>	
<p>a) Unauthorized purchases by me of personal goods on Company accounts or unauthorized use by me of Company Credit Card (if applicable);</p> <p>b) Fines associated with photo radar, red light or other traffic violations relating to a Company vehicle operated by me;</p> <p>c) Costs resulting from damage by me to property of Company or its customers (including vehicles) that is willful or negligent;</p> <p>d) My unpaid/unauthorized accommodation costs and expenses, including, but not limited to meals, phone calls, damages, movie rentals, etc.;</p> <p>e) Safety Boots Program cost and/or Prescription Safety Glasses Program cost, if my employment is terminated (voluntarily or involuntarily) within six (6) months of being issued a voucher through this program;</p> <p>f) If immediately required for my position, the cost associated with the Company obtaining a Commercial Driver's Abstract on my behalf if I am unable to provide this when initially hired;</p> <p>g) *Actual Mandatory Safety Training course costs in the following circumstances:</p> <ul style="list-style-type: none"><li>(i) if I fail to attend a scheduled training course;</li><li>(ii) if I do not pass or complete a training course;</li><li>(iii) if I do not pass my ninety (90) day probationary period with Savanna; or</li><li>(iv) if I voluntarily resign or am terminated for cause within six (6) months of course completion.</li></ul> <p>h) *Actual Pre-employment Testing (drug and alcohol testing) costs in the following circumstances:</p> <ul style="list-style-type: none"><li>(i) If I request unpaid time off or unpaid leave of absence during my ninety (90) day probationary period (reimbursed upon return to work);</li><li>(ii) if I do not pass my ninety (90) day probationary period with Savanna; or</li><li>(iii) if I voluntarily resign prior to the expiration of my ninety (90) day probationary period.</li></ul> <p>i) *Actual Unreturned Mandatory Safety Equipment (PPE) costs in the following circumstances:</p> <ul style="list-style-type: none"><li>(i) If I request unpaid time off or unpaid leave of absence during my ninety (90) day probationary period (reimbursed upon return to work);</li><li>(ii) If I do not pass my ninety (90) day probationary period with Savanna; or</li><li>(iii) If I voluntarily resign prior to the expiration of my ninety (90) day probationary period.</li></ul> <p><b>*Current Deductible Costs known to Savanna are listed in the attached Schedule "A"</b></p>	
<p><b>Employee Acknowledgement and Signature:</b> By signing below, I confirm that I have reviewed this form and irrevocably authorize Savanna to deduct through payroll (including my final pay) costs for the items as stated above.</p>	
<b>Employee Name:</b> (please print)	
<b>Employee Signature:</b>	
<b>Date:</b>	
<b>Witness Name:</b> (please print)	
<b>Witness Signature:</b>	
<p><i>Please complete, sign and return to your Crew Coordinator and/or HR Representative.</i></p>	





## SCHEDULE "A" DEDUCTIBLE COSTS (Updated January 1, 2025)

### **\*\*Mandatory Safety Training Costs:**

(Actual cost of training as required under Savanna's *Health Safety Environment Management System* manual and training matrix or as otherwise requested by Savanna for business needs) - As applicable

Common Safety Orientation	\$70.00
CAODC Floorhand Competency Book	\$55.00
CAODC Derrickhand Competency Book	\$55.00
CAODC Driller/Operator Competency Book	\$55.00
H2S Alive	\$185.00
Standard First Aid	\$195.00
BC First Aid OFA Level 1	\$205.00
Airbrakes	\$200.00
Confined Space Entry	\$200.00
ESC Fall Protection	\$185.00
ESC Rig Rescue	\$350.00
Detection and Control	\$150.00
Special Oilwell Boiler	\$800.00
Well Service BOP	\$685.00 - \$890.00 (Range)

SureHire - Audiogram and mask fit test (x2): \$110.00 - Power Center

SureHire - Audiogram and mask fit test (x2): \$146.75 - Canada Wide (Annual)

ECS - Audiogram and mask fit test (x2): \$90.00 (Annual)

### **\*\*Pre-employment Testing Costs:**

(Actual cost of testing by provider - average cost listed)

*Current providers are SureHire and ECS Occupational Testing*

SureHire - Power Centre costs: \$428.00

SureHire - Canada Wide costs: \$578.75

ECS costs: \$357.00

### **\*\*Safety Boots Program Costs:**

\$250.00 plus applicable taxes

### **\*\*Prescription Safety Glasses Program Cost:**

\$200.00

### **Unreturned Mandatory Safety Equipment Costs:**

Pair of Coveralls \$122.00 - \$128.00

Hard hat \$40.00

Impact gloves \$16.55 - \$33.00

### **\*\*Commercial Driver's Abstract:**

\$15 plus applicable fees (if any)

***\*\*The above indicated amounts are average costs and subject to change without notice by third party provider. Actual costs will be confirmed prior to payroll deduction.***



## 2025 Personal Tax Credits Return

TD1

Read page 2 before filling out this form. Your employer or payer will use this form to determine the amount of your tax deductions.

Fill out this form based on the best estimate of your circumstances.

If you do not fill out this form, your tax deductions will only include the basic personal amount, estimated by your employer or payer based on the income they pay you.

Last name		First name and initial(s)		Date of birth (YYYY/MM/DD)		Employee number	
Address		Postal code		For non-residents only Country of permanent residence		Social insurance number	

**1. Basic personal amount** – Every resident of Canada can enter a basic personal amount of \$16,129. However, if your net income from all sources will be greater than \$177,882 and you enter \$16,129, you may have an amount owing on your income tax and benefit return at the end of the tax year. If your income from all sources will be greater than \$177,882 you have the option to calculate a partial claim. To do so, fill in the appropriate section of Form TD1-WS, Worksheet for the 2025 Personal Tax Credits Return, and enter the calculated amount here.

**2. Canada caregiver amount for infirm children under age 18** – Only one parent may claim \$2,687 for each infirm child born in 2008 or later who lives with both parents throughout the year. If the child does not live with both parents throughout the year, the parent who has the right to claim the "Amount for an eligible dependant" on line 8 may also claim the Canada caregiver amount for the child.

**3. Age amount** – If you will be 65 or older on December 31, 2025, and your net income for the year from **all** sources will be \$45,522 or less, enter \$9,028. You may enter a partial amount if your net income for the year will be between \$45,522 and \$105,709. To calculate a partial amount, fill out the line 3 section of Form TD1-WS.

**4. Pension income amount** – If you will receive regular pension payments from a pension plan or fund (not including Canada Pension Plan, Quebec Pension Plan, old age security, or guaranteed income supplement payments), enter **whichever is less**: \$2,000 or your estimated annual pension income.

**5. Tuition (full-time and part-time)** – Fill in this section if you are a student at a university or college, or an educational institution certified by Employment and Social Development Canada, and you will pay more than \$100 per institution in tuition fees. Enter the total tuition fees that you will pay if you are a full-time or part-time student.

**6. Disability amount** – If you will claim the disability amount on your income tax and benefit return by using Form T2201, Disability Tax Credit Certificate, enter \$10,138.

**7. Spouse or common-law partner amount** – Enter the difference between the amount on line 1 (line 1 plus \$2,687 if your spouse or common-law partner is **infirm**) and your spouse's or common-law partner's estimated net income for the year if **two** of the following conditions apply:

- You are supporting your spouse or common-law partner who lives with you
- Your spouse or common-law partner's net income for the year will be less than the amount on line 1 (line 1 plus \$2,687 if your spouse or common-law partner is **infirm**)

In all cases, go to line 9 if your spouse or common-law partner is **infirm** and has a net income for the year of \$28,798 or less.

**8. Amount for an eligible dependant** – Enter the difference between the amount on line 1 (line 1 plus \$2,687 if your eligible dependant is **infirm**) and your eligible dependant's estimated net income for the year if **all** of the following conditions apply:

- You do **not** have a spouse or common-law partner, or you **have** a spouse or common-law partner who does not live with you and who you are not supporting or being supported by
- You are supporting the dependant who is related to you and lives with you
- The dependant's net income for the year will be less than the amount on line 1 (line 1 plus \$2,687 if your dependant is **infirm** and you **cannot** claim the **Canada caregiver amount for infirm children under 18 years of age** for this dependant)

In all cases, go to line 9 if your dependant is **18 years or older, infirm**, and has a net income for the year of \$28,798 or less.

**9. Canada caregiver amount for eligible dependant or spouse or common-law partner** – Fill out this section if, at any time in the year, you support an **infirm** eligible dependant (aged 18 or older) **or** an **infirm** spouse or common-law partner whose net income for the year will be \$28,798 or less. To calculate the amount you may enter here, fill out the line 9 section of Form TD1-WS.

**10. Canada caregiver amount for dependant(s) age 18 or older** – If, at any time in the year, you support an **infirm** dependant age 18 or older (**other than** the spouse or common-law partner or eligible dependant you claimed an amount for on line 9 or could have claimed an amount for if their net income were under \$18,816) whose net income for the year will be \$20,197 or less, enter \$8,601. You may enter a partial amount if their net income for the year will be between \$20,197 and \$28,798. To calculate a partial amount, fill out the line 10 section of Form TD1-WS. This worksheet may also be used to calculate your part of the amount if you are sharing it with another caregiver who supports the same dependant. You may claim this amount for more than one infirm dependant age 18 or older.

**11. Amounts transferred from your spouse or common-law partner** – If your spouse or common-law partner will not use all of their age amount, pension income amount, tuition amount, or disability amount on their income tax and benefit return, enter the unused amount.

**12. Amounts transferred from a dependant** – If your dependant will not use all of their disability amount on their income tax and benefit return, enter the unused amount. If your or your spouse's or common-law partner's dependent child or grandchild will not use all of their tuition amount on their income tax and benefit return, enter the unused amount.

**13. TOTAL CLAIM AMOUNT** – Add lines 1 to 12.  
Your employer or payer will use this amount to determine the amount of your tax deductions.

**Filling out Form TD1**

Fill out this form **only** if any of the following apply:

- you have a new employer or payer, and you will receive salary, wages, commissions, pensions, employment insurance benefits, or any other remuneration
- you want to change the amounts you previously claimed (for example, the number of your eligible dependants has changed)
- you want to claim the deduction for living in a prescribed zone
- you want to increase the amount of tax deducted at source

Sign and date it, and give it to your employer or payer.

**More than one employer or payer at the same time**

☐ If you have more than one employer or payer at the same time and you have already claimed personal tax credit amounts on another Form TD1 for 2025, you **cannot** claim them again. If your total income from all sources will be more than the personal tax credits you claimed on another Form TD1, check this box, enter "0" on Line 13 and do not fill in Lines 2 to 12.

**Total income is less than the total claim amount**

☐ Tick this box if your total income for the year from **all** employers and payers will be **less** than your total claim amount on line 13. Your employer or payer will not deduct tax from your earnings.

**For non-resident only (Tick the box that applies to you.)**

As a non-resident, will 90% or more of your world income be included in determining your taxable income earned in Canada in 2025?

☐ Yes (Fill out the previous page.)

☐ No (Enter "0" on line 13, and do not fill in lines 2 to 12 as you are not entitled to the personal tax credits.)

Call the international tax and non-resident enquiries line at **1-800-959-8281** if you are unsure of your residency status.

**Provincial or territorial personal tax credits return**

You also have to fill out a provincial or territorial TD1 form if your claim amount on line 13 is more than \$16,129. Use the Form TD1 for your province or territory of **employment** if you are an employee. Use the Form TD1 for your province or territory of **residence** if you are a pensioner. Your employer or payer will use both this federal form and your most recent provincial or territorial Form TD1 to determine the amount of your tax deductions.

Your employer or payer will deduct provincial or territorial taxes after allowing the provincial or territorial basic personal amount if you are claiming the basic personal amount **only**.

**Note:** You may be able to claim the child amount on Form TD1SK, 2025 Saskatchewan Personal Tax Credits Return if you are a Saskatchewan resident supporting children under 18 at any time during 2025. Therefore, you may want to fill out Form TD1SK even if you are **only** claiming the basic personal amount on this form.

**Deduction for living in a prescribed zone**

You may claim **any** of the following amounts if you live in the Northwest Territories, Nunavut, Yukon, or another prescribed **northern** zone for more than six months in a row beginning or ending in 2025:

- \$11.00 for each day that you live in the prescribed northern zone
- \$22.00 for each day that you live in the prescribed northern zone if, during that time, you live in a dwelling that you maintain, and you are the only person living in that dwelling who is claiming this deduction

Employees living in a prescribed **intermediate** zone may claim 50% of the total of the above amounts.

For more information, go to **canada.ca/taxes-northern-residents**.

\$

**Additional tax to be deducted**

You may want to have more tax deducted from each payment if you receive other income such as non-employment income from CPP or QPP benefits, or old age security pension. You may have less tax to pay when you file your income tax and benefit return by doing this. Enter the additional tax amount you want deducted from each payment to choose this option. You may fill out a new Form TD1 to change this deduction later.

\$

**Reduction in tax deductions**

You may ask to have less tax deducted at source if you are eligible for deductions or non-refundable tax credits that are not listed on this form (for example, periodic contributions to a registered retirement savings plan (RRSP), child care or employment expenses, charitable donations, and tuition and education amounts carried forward from the previous year). To make this request, fill out Form T1213, Request to Reduce Tax Deductions at Source, to get a letter of authority from your tax services office. Give the letter of authority to your employer or payer. You do not need a letter of authority if your employer deducts RRSP contributions from your salary.

**Forms and publications**

To get our forms and publications, go to **canada.ca/cra-forms-publications** or call **1-800-959-5525**.

Personal information (including the SIN) is collected and used to administer or enforce the Income Tax Act and related programs and activities including administering tax, benefits, audit, compliance, and collection. The information collected may be disclosed to other federal, provincial, territorial, aboriginal or foreign government institutions to the extent authorized by law. Failure to provide this information may result in paying interest or penalties, or in other actions. Under the Privacy Act, individuals have a right of protection, access to and correction of their personal information, and to file a complaint with the Privacy Commissioner of Canada regarding the handling of their personal information. Refer to Personal Information Bank CRA PPU 120 on Info Source at **canada.ca/cra-info-source**.

**Certification**

I certify that the information given on this form is correct and complete.

Signature

It is a serious offence to make a false return.

Date

**Read page 2 before filling out this form. Your employer or payer will use this form to determine the amount of your provincial tax deductions.**

Fill out this form based on the best estimate of your circumstances.

<b>Last name</b>	<b>First name and initial(s)</b>	<b>Date of birth (YYYY/MM/DD)</b>	<b>Employee number</b>
<b>Address</b>	<b>Postal code</b>	<b>For non-residents only</b> Country of permanent residence	<b>Social insurance number</b>

**1. Basic personal amount** – Every person employed in Alberta and every pensioner residing in Alberta can claim this amount. If you will have more than one employer or payer at the same time in 2025, see "More than one employer or payer at the same time" on page 2

**2. Age amount** – If you will be 65 or older on December 31, 2025, and your net income from all sources will be \$46,308 or less, enter \$6,221. You may enter a partial amount if your net income for the year will be between \$46,308 and \$87,782. To calculate a partial amount, fill out the line 2 section of Form TD1AB-WS, Worksheet for the Alberta 2025 Personal Tax Credits Return.

**3. Pension income amount** – If you will receive regular pension payments from a pension plan or fund (not including Canada Pension Plan, Quebec Pension Plan, old age security, or guaranteed income supplement payments), **enter whichever is less:** \$1,719 or your estimated annual pension.

**4. Disability amount** – If you will claim the disability amount on your income tax and benefit return by using Form T2201, Disability Tax Credit Certificate, enter \$17,219.

**5. Spouse or common-law partner amount** – Enter the difference between the amount on line 1 and your spouse's or common-law partner's estimated net income for the year if **all** of the following conditions apply:

- You are supporting your spouse or common-law partner
- Your spouse or common-law partner lives with you
- Your spouse's or common-law partner's net income for the year will be less than the amount on line 1

**6. Amount for an eligible dependant** – Enter the difference between the amount on line 1 and your eligible dependant's estimated net income for the year if **all** of the following conditions apply:

- You do **not** have a spouse or common-law partner, or you **have** a spouse or common-law partner who does not live with you and who you are not supporting or being supported by
- The dependant is related to you and lives with you
- The dependant's net income for the year will be less than the amount on line 1

**7. Caregiver amount** – Enter \$12,922 if you are taking care of a dependant and **all** of the following conditions apply:

- The dependant is your or your spouse's or common-law partner's parent or grandparent (aged 65 or older) or an infirm relative (aged 18 or older)
- The dependant lives with you
- The dependant has a net income of \$20,545 or less for the year

You may enter a partial amount if the dependant's net income for the year will be between \$20,545 and \$33,467. To calculate a partial amount, fill out the line 7 section of Form TD1AB-WS.

**8. Amount for infirm dependants age 18 or older** – Enter \$12,922 if you are supporting an **infirm** dependant and **all** of the following conditions apply:

- The dependant lives in Canada and is related to you or your spouse or common-law partner
- The dependant is 18 years or older
- The dependant has a net income of \$8,536 or less for the year

You may enter a partial amount if the infirm dependant's net income for the year will be between \$8,536 and \$21,458. To calculate a partial amount, fill out the line 8 section of Form TD1AB-WS. You **cannot** claim an amount for a dependant you claimed on line 7.

**9. Amounts transferred from your spouse or common-law partner** – If your spouse or common-law partner will not use all of their age amount, pension income amount, or disability amount on their income tax and benefit return, enter the unused amount.

**10. Amounts transferred from a dependant** – If your dependant will not use all of their disability amount on their income tax and benefit return, enter the unused amount.

**11. TOTAL CLAIM AMOUNT** – Add lines 1 to 10.

Your employer or payer will use your claim amount to determine the amount of your provincial tax deductions.

**22,323**

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**Filling out Form TD1AB**

Fill out this form if you have income in Alberta and **any** of the following apply:

- you have a new employer or payer, and you will receive salary, wages, commissions, pensions, employment insurance benefits, or any other remuneration
- you want to change the amounts you previously claimed (for example, the number of your eligible dependants has changed)
- you want to increase the amount of tax deducted at source

Sign and date it, and give it to your employer or payer.

If you do not fill out Form TD1AB, your employer or payer will deduct taxes after allowing the basic personal amount **only**.

**More than one employer or payer at the same time**

- ☐ If you have more than one employer or payer at the same time and you have already claimed personal tax credit amounts on another Form TD1AB for 2025, you **cannot** claim them again. If your total income from all sources will be more than the personal tax credits you claimed on another Form TD1AB, check this box, enter "0" on line 11 and do not fill in lines 2 to 10

**Total income is less than the total claim amount**

- ☐ Tick this box if your total income for the year from **all** employers and payers will be **less** than your total claim amount on line 11. Your employer or payer will not deduct tax from your earnings.

**Additional tax to be deducted**

If you want to have more tax deducted at source, fill out section "Additional tax to be deducted" on the federal Form TD1.

**Reduction in tax deductions**

You may ask to have less tax deducted at source if you are eligible for deductions or non-refundable tax credits that are not listed on this form (for example, periodic contributions to a registered retirement savings plan (RRSP), child care or employment expenses, charitable donations, and tuition and education amounts carried forward from the previous year). To make this request, fill out Form T1213, Request to Reduce Tax Deductions at Source, to get a letter of authority from your tax services office. Give the letter of authority to your employer or payer. You do not need a letter of authority if your employer deducts RRSP contributions from your salary.

**Forms and publications**

To get our forms and publications, go to [canada.ca/cra-forms-publications](https://canada.ca/cra-forms-publications) or call 1-800-959-5525.

Personal information (including the SIN) is collected and used to administer or enforce the Income Tax Act and related programs and activities including administering tax, benefits, audit, compliance, and collection. The information collected may be disclosed to other federal, provincial, territorial, aboriginal or foreign government institutions to the extent authorized by law. Failure to provide this information may result in paying interest or penalties, or in other actions. Under the Privacy Act, individuals have a right of protection, access to and correction of their personal information, and to file a complaint with the Privacy Commissioner of Canada regarding the handling of their personal information. Refer to Personal Information Bank CRA PPU 120 on Info Source at [canada.ca/cra-info-source](https://canada.ca/cra-info-source).

**Certification**

I certify that the information given on this form is correct and complete.

Signature

Date

It is a serious offence to make a false return.



Savanna Well Servicing Inc.  
Suite 1000, 734 7 Avenue SW  
Calgary, Alberta T2P 3P8  
P. 403 503 9990 F. 403 503 0654  
[www.savannaenergy.com](http://www.savannaenergy.com)

## MEMORANDUM

TO: All Well Servicing Employees

SUBJECT: **2025 TD4 Forms and Subsistence Payments**

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Field employees in our Canadian Well Servicing division are required to fill out one **TD4 form** and a **TD4 Letter of Responsibility** form on an annual basis.

For any recalls or rehires within the year, it is the employee's responsibility to contact the payroll department to ensure that we have a form on file for 2025 year. Please note that new hires will be filling out the form as part of their new hire package.

The **TD4 Letter of Responsibility** is a document stating that the employee is responsible to notify Payroll if he/she is returning home daily from the rig location or if they no longer satisfy the conditions on the TD4 form. Please write your name, sign and date this document.

Employees who are not staying in a camp and do not meet the criteria above are to immediately notify Payroll. Failure to comply with the above policies could result in employees being audited and potential penalties and interest owed to CRA.

**Rig Managers:** Please mark the "TD4" boxes for each employee's time sheet in CRM. Enter "Yes" if the employee is in fact staying in a non-camp location and eligible for non-tax subsistence and a "No" if the employee is returning home daily.

**Rig Managers:** Please ensure copies of these forms and this email are made available to the employees on your rigs.

**Please return the signed forms to the payroll office. If these forms are not returned your subsistence will be fully taxable.**

Forms should be submitted to: Payroll and your Crew Coordinator

[SWSCA-Payroll@savannawellservicing.com](mailto:SWSCA-Payroll@savannawellservicing.com)

Should you have any questions, please call Iryna Timofyeyeva at 403-218-8095 and leave a message. Your call will be returned within 2 working days.



### Declaration of Exemption - Employment at a Special Work Site

- My principal place of residence is available for me to live in. I do not rent it to anyone.
- Because of the distance between my principal place of residence and the special work site, I am not expected to commute between the two while I am working at that location.
- My work requires me to be away from my principal place of residence for at least 36 hours, including the time I spend travelling between my principal place of residence and the special work site.

- The duties the employees must perform at the special work site are temporary in nature and, by reason of distance, the employees are not expected to return daily to their principal places of residence.
- The board and lodging provided, or the allowance received by the employees have been for a period of at least 36 hours spent at the special work site (including the time the employees spend travelling between work and residence).
- The benefits or allowances for transportation given to the employees relate only to the period the employees receive the allowances, or their value for board and lodging.

By signing below, you acknowledge that you have read, understood, and accept the terms and conditions outlined in this document.

Date Signed



## Declaration of Exemption – Employment at a Special Work Site

### Who can use this form?

Use this form if you are an employee who works at a special work site. It will allow your employer to determine if the following benefits can be excluded from your income:

- the value of, or an allowance (not in excess of a reasonable amount) for expenses for, board and lodging provided by your employer at a special work site
- the value of, or an allowance (not in excess of a reasonable amount) for expenses for, transportation to and from your principal place of residence and a special work site

Your employer will exclude these benefits or allowances from your income if **all** the conditions explained below are met.

You and your employer should fill out this form when you begin your employment at a special work site or if your employment situation at a special work site changes.

For more details, see Interpretation Bulletin IT-91, Employment at Special Work Sites or Remote Work Locations.

### Employee information (please print)

Last name		First name and initial(s)		Social Insurance Number	
Address of your principal place of residence (self-contained domestic establishment)				Postal code	
Number of kilometers between your principal place of residence and the special work site (one way)		Varied		Location where you live while you are employed at the special work site	
		km		Many Various Locations	

### Employee's certification

I certify that I meet <b>all</b> of the following conditions:					
<ul style="list-style-type: none"> <li>I maintain a self-contained domestic establishment as my principal place of residence at the address above.</li> <li>My principal place of residence is available for me to live in. I do not rent it to anyone.</li> <li>By reason of the distance between my principal place of residence and the special work site, I am not expected to commute between the two while I am working at that location.</li> <li>My work requires me to be away from my principal place of residence for at least 36 hours, including the time I spend travelling between my principal place of residence and the special work site.</li> </ul>					
Year	Month	Day	Signature of employee		

### Employer information (please print)

Name of employer		Savanna Well Servicing Inc													
Address		Suite 1000, 734 - 7 Ave SW, Calgary, AB T2P 3P8													
Type of business	Oil & Gas Well Servicing	Account number (from Form PD7A, Remittance voucher)													
Name of proprietors or partners (if applicable)															
Exact location of the special work site (including the municipality)		The benefits or allowances below are available under:													
Many various well site locations - AB / SK / BC		<input type="checkbox"/> collective agreement <input checked="" type="checkbox"/> company policy													
Period of work at the special work site requiring the employee to be away from his or her principal place of residence for at least 36 hours.		From <table border="1"> <tr> <td>Year</td><td>Month</td><td>Day</td></tr> <tr> <td>2024</td><td>12</td><td>29</td></tr> </table> to <table border="1"> <tr> <td>Year</td><td>Month</td><td>Day</td></tr> <tr> <td>2025</td><td>12</td><td>20</td></tr> </table>		Year	Month	Day	2024	12	29	Year	Month	Day	2025	12	20
Year	Month	Day													
2024	12	29													
Year	Month	Day													
2025	12	20													

### Employer details of benefits or allowances (give an estimate if you do not know the exact amount)

	Board	Lodging	Board and lodging	Transportation	Other
Amount paid to employee for:	\$	\$	\$	\$	\$
Value of free:	\$	\$	\$	\$	\$

Continued on next page



**Employer's certification**

I certify that **all** of the following conditions are met:

- The duties the employee has to perform at the special work site are temporary and, by reason of distance, the employee is not expected to return daily to his or her principal place of residence.
- The board and lodging provided or the allowance received by the employee have been for a period of at least 36 hours spent at the special work site (including the time the employee spends travelling between the principal place of residence and the special work site).
- The benefits or allowances for transportation given to the employee relate only to the period the employee also receives the value of, or allowances for, board and lodging.

After you complete this form with your employee, keep it with your payroll records in case we ask to see it.

Year	Month	Day	Signature of employer or authorized officer

**Note:** Employers should contact their tax services office if they receive a Form TD4 with doubtful statements. Any person who knowingly completes or accepts a Form TD4 with false or deceptive statements commits an offence.

Personal information (including the SIN) is collected for the purposes of the administration or enforcement of the Income Tax Act and related programs and activities including administering tax, benefits, audit, compliance, and collection. The information collected may be used or disclosed for purposes of other federal acts that provide for the imposition and collection of a tax or duty. It may also be disclosed to other federal, provincial, territorial, or foreign government institutions to the extent authorized by law. Failure to provide this information may result in interest payable, penalties, or other actions. Under the Privacy Act, individuals have a right of protection, access to and correction of their personal information, or to file a complaint with the Privacy Commissioner of Canada regarding the handling of their personal information. Refer to Personal Information Bank CRA PPU 120 on Info Source at [canada.ca/cra-info-source](http://canada.ca/cra-info-source).

## **INSTRUCTIONS: DETERMINATION OF EXEMPTION FORM TD1-IN**

For new employees, you may complete the following TD1-IN form if you self-identify as an Indigenous person in Canada and if you anticipate that you may work on a reserve.

If this may not pertain to you, you may leave the following form blank.

Please note, the terms used below and on this form are taken directly from the Government of Canada website.

**Please complete the following TD1-IN form if you are an individual who:**

(1) Is an Indigenous person as defined in the Indian Act

**and**

(2) Think your income is tax exempt or partially tax exempt.

This form will be used to determine the correct tax treatment of your income.

If you may have any questions about this form, please contact Savanna's Payroll team at [swsca-payroll@savannawellservicing.com](mailto:swsca-payroll@savannawellservicing.com)

## Determination of Exemption of an Indian's Employment Income

The term "employee" on this form refers only to an employee who is an Indian as defined in the Indian Act.

Use this form if you think your income is tax exempt or partially tax exempt. Your employer will use your answers in Part 1 to help determine the correct tax treatment of your income.

You and your employer should fill out this form, in addition to Form TD1. You must fill out these forms when you start a new job on a reserve or if your employment situation on a reserve changes. For more information about employee and employer responsibilities, go to [canada.ca/tax-filing-form-td1](https://canada.ca/tax-filing-form-td1)

### Part 1 – Employee information (to be filled out by the employee)

#### 1.1 Are you registered under the Indian Act?

- ☐ Yes. Continue to Section 1.2.  
☐ No. **Do not** use this form.

For more information, go to [canada.ca/indian-status](https://canada.ca/indian-status)

#### 1.2 Are you a treaty beneficiary of a First Nation with a final or self-government agreement that ends the tax exemption under section 87 of the Indian Act?

- ☐ Yes. **Do not** use this form.  
☐ No. Continue to section 1.3.

To confirm the effective date of the agreements and the expiry dates, go to [canada.ca/tax-indigenous-end-dates](https://canada.ca/tax-indigenous-end-dates)

#### 1.3 Fill out your name and address. Continue to section 1.4.

Last name (please print)	First name and initials	Social insurance number
Address of principal place of residence including postal code		

#### 1.4 Do you live on a reserve? This means it is your principal place of residence and is the centre of your daily routine.

- ☐ Yes ☐ No

### Employee Certification

I certify that the following information is correct and complete:

- I am registered under the Indian Act
- I am **not** a treaty beneficiary of a First Nation with a final or self-government agreement that ends the tax exemption under section 87 of the Indian Act
- If I answered yes in section 1.4, I live on a reserve, it is my principal place of residence and is the centre of my daily routine

Signature \_\_\_\_\_ Date \_\_\_\_\_



## Self-Identification Questionnaire

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Savanna Well Servicing Inc. (“Savanna”) is committed to creating an environment that reflects a diverse workforce. We believe in working together to understand, identify, and create balance between business opportunities and contributing to the well-being of communities.

Savanna has a long history of engagement with local and Indigenous communities in the areas where the company operates. To learn more about the company’s Indigenous and Community relations, visit: <https://www.totalenergy.ca/about-us/indigenous-and-community-relations/>

The information collected in this questionnaire is confidential and will only be used and/or disclosed by Savanna to our Indigenous Partnerships in accordance with the company’s “Employee Privacy Policy”. The response you provide may be reported externally in aggregate for statistical purposes.

This questionnaire will help us gain a better insight of the diversity in our workforce and it is **completely voluntary**. Should you choose to not participate, please indicate below.

Date	<input type="checkbox"/> I elect not to provide this information
Employee Full Name	
Employee Signature	

*For the purpose of this questionnaire, Indigenous persons include people who identify as First Nations (Status, Non-Status, Treaty), Metis, Inuit, Native or North American Indian (including North and Central America and the Caribbean).*

Are you of Indigenous ancestry?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please identify which indigenous community you belong to.	
Please identify what community or band you belong to.	

Savanna’s Human Resources team appreciates and values your participation in this questionnaire. If you have any questions or concerns regarding this questionnaire, please do not hesitate to contact your Crew Coordinator or a Savanna Human Resources Representative, through the following e-mail: [swsca-humanresources@savannawellservicing.com](mailto:swsca-humanresources@savannawellservicing.com)


**INDUSTRIAL  
ALLIANCE**

INSURANCE AND FINANCIAL SERVICES

# ENROLMENT REQUEST

As plan administrator, if you use Web@dmin to enrol the plan member, please keep the form for your records. If you do not use Web@dmin, submit a copy of the form to Industrial Alliance and retain the original. You can submit the copy of the form by:

**Fax:** 1-877-392-6487

**Mail: Quebec**

PO Box 790, Station B  
Montreal, Quebec H3B 3K6

**All Other Provinces**

522 University Avenue, Suite 400  
Toronto, Ontario M5G 1Y7

## TO BE COMPLETED AND SIGNED BY THE PLAN ADMINISTRATOR (Please print in ink)

Policyholder's name \_\_\_\_\_ Group policy no. \_\_\_\_\_  
(Employer/organization)

Division no. \_\_\_\_\_ Class no. \_\_\_\_\_ ☐ Certificate no. \_\_\_\_\_

Location no. or name (if applicable) \_\_\_\_\_ ☐ Certificate no. to be assigned by the insurer

Plan member's occupation \_\_\_\_\_

Employment date 

Y	M	D
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 Eligibility date 

Y	M	D
---	---	---

 For reinstatement, give date rehired full time 

Y	M	D
---	---	---

If you waived the waiting period, please explain why: \_\_\_\_\_

Salary \$ \_\_\_\_\_ ☐ Annually ☐ Biweekly ☐ Hourly – Hours worked/week \_\_\_\_\_  
☐ Monthly ☐ Semimonthly ☐ Weekly

Plan administrator's signature \_\_\_\_\_ Date 

Y	M	D
---	---	---

Plan administrator's email \_\_\_\_\_ Tel. no. \_\_\_\_\_

## TO BE COMPLETED AND SIGNED BY THE PLAN MEMBER (Please print in ink)

### 1. PLAN MEMBER INFORMATION

Last name \_\_\_\_\_ First name \_\_\_\_\_

Address \_\_\_\_\_  
No. \_\_\_\_\_ Street \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal code \_\_\_\_\_

Date of birth 

Y	M	D
---	---	---

 Sex: ☐ Male ☐ Female Language: ☐ English ☐ French

### Direct deposit of your health and/or dental claim reimbursements and notification\* of claim processing

Banking information for direct deposit:

Transit #	Institution #	Account #
1	2	3
	4	

- 1 Cheque number (do not write this number).
- 2 Transit number (5 digits).
- 3 Financial institution number (3 digits).
- 4 Account number. The format may vary from one financial institution to another. Indicate all numbers and only the numbers.

Email address for notification\*: \_\_\_\_\_

☐ Personal ☐ Work

☐ I do not want to be notified

\* You will be considered as having refused the notification if you do not provide your banking information or your email address or if you check "I do not want to be notified".

Note: You can view the status and details of your health and/or dental claims via CyberClient, our secure website, at any time.

Please complete the 4 pages of this form and sign the "PLAN MEMBER CONFIRMATION/AUTHORIZATION" section.

**IMPORTANT:** The basic dependents' life insurance coverage will be automatically applied if your plan includes this benefit and your dependents (spouse and children) are eligible. This requirement applies regardless of the coverage chosen for the health and dental benefits (individual, family, single parent, couple or refused coverage).

2. SPOUSE INFORMATION

Last name \_\_\_\_\_ First name \_\_\_\_\_

Date of birth 

Y					
M					
D					

 Sex: ☐ Male ☐ Female

Is your spouse covered by another group insurance plan for health and dental benefits? ☐ Yes ☐ No

If Yes, specify his/her: Health coverage: ☐ Individual ☐ Family ☐ Single parent ☐ Couple

Dental coverage: ☐ Individual ☐ Family ☐ Single parent ☐ Couple

Insurer's name \_\_\_\_\_

Group policy no. \_\_\_\_\_ Certificate no. \_\_\_\_\_

Note: If your spouse is a common-law spouse, please contact your plan administrator to confirm his/her eligibility.

3. DEPENDENT CHILDREN INFORMATION (if more space is required, please use another sheet. Date and sign any attached document.)

Last name	First name	Sex	Date of birth	If age 21* or over, specify		
		<input type="checkbox"/> M <input type="checkbox"/> F	Y M D       	Full-time student	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F	Y M D       	Handicapped	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F	Y M D       	Full-time student	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F	Y M D       	Handicapped	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F	Y M D       	Full-time student	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F	Y M D       	Handicapped	<input type="checkbox"/> Yes	<input type="checkbox"/> No

\* The age limit may vary depending on your plan. Please contact your plan administrator to confirm this information.

If one of your dependent children is covered by a group insurance plan other than yours or your spouse's, complete the following table:

Child Last name, First name	Plan type (e.g. school plan, etc.)	Insurer name	Group policy no.

4. CHOICE OF COVERAGE

Coverage requested\*: ☐ Individual ☐ Family ☐ Single parent ☐ Couple

Plan/Option/Module (if applicable) \_\_\_\_\_

\*If you and/or your dependents **already have health and/or dental coverage under another group plan**, you can refuse to be covered for health and/or dental benefits under this group plan by checking the following boxes:

For myself and my dependents: ☐ I refuse health benefits ☐ I refuse dental benefits

For my dependents only: ☐ I refuse health benefits ☐ I refuse dental benefits

Note: If you refuse coverage and wish to request it at a later date, certain conditions may apply. Please contact your plan administrator for further details.

## 5. OPTIONAL BENEFITS

**IMPORTANT:** Before completing this section, check with your plan administrator if optional benefits are offered as part of your group plan and if you should complete the *Evidence of Insurability* form (F54-002A).

	Life*	Accidental Death and Dismemberment*	Critical Illness*	Statement (Complete only if you want to add optional life and/or optional critical illness benefits)
<b>Plan member</b>	\$ _____	\$ _____	\$ _____	In the last twelve months, have you used tobacco in any form whatsoever, nicotine products (gum, patches, etc.) or marijuana? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Spouse</b>	\$ _____	\$ _____	\$ _____	In the last twelve months, has your spouse used tobacco in any form whatsoever, nicotine products (gum, patches, etc.) or marijuana? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Children</b>	\$ _____	\$ _____	\$ _____	Each child will benefit from the coverage amount you selected.

\*Please indicate the coverage amount to be added. Do not include basic coverage.

## 6. APPOINTMENT OF BENEFICIARY (If you do not designate a beneficiary, the benefit will be payable to the estate.)

### 1. Primary beneficiaries

If you name multiple primary beneficiaries, the total allocation must be equal to or less than 100%; if less than 100%, the difference will be payable to the estate. Please do not indicate dollar amounts.

Last name	First name	Relationship	Date of birth	%
			Y M D 	
			Y M D 	
			Y M D 	

### 2. Contingent beneficiaries

If you wish, you can also appoint contingent beneficiaries in the event **all** primary beneficiaries predecease you. If you name multiple contingent beneficiaries, the total allocation must be equal to or less than 100%. If less than 100%, the difference will be payable to the estate. Please do not indicate dollar amounts.

Last name	First name	Relationship	Date of birth	%
			Y M D 	
			Y M D 	

**IMPORTANT: For Quebec residents only – to be completed if you designated your spouse (marriage or civil union) as a beneficiary.**

In Quebec, the designation of a spouse, excluding a common-law spouse, as a beneficiary is irrevocable\* unless you check the following box:

☐ Revocable beneficiary

\*To change the appointment of an irrevocable beneficiary, his/her written consent will be required.

## 7. TRUSTEE DESIGNATION (Not applicable in Quebec.)\*

You can appoint a Trustee to receive any amount due to any beneficiary under the age of majority.

Trustee's last name \_\_\_\_\_ First name \_\_\_\_\_

\*In Quebec, there might be issues with respect to the appointment of a trustee. You should consult a legal advisor before appointing a trustee.

Please sign the "PLAN MEMBER CONFIRMATION/AUTHORIZATION" section on the next page.

## PLAN MEMBER CONFIRMATION/AUTHORIZATION

**I HEREBY APPLY** for the benefits which I am eligible for under my Employer's/Policyholder's group insurance plan, subject to any waiver indicated and **CONFIRM** that the information contained in this form is true and complete to the best of my knowledge.

If applying for benefits for my dependents, **I CONFIRM THAT I AM AUTHORIZED** to disclose information concerning them for the purpose of determining their eligibility for coverage.

On behalf of myself and my dependents, **I CONSENT TO THE RELEASE** of the information contained in this form to my Employer/Policyholder and Industrial Alliance, its employees, agents, reinsurers and service providers for the purpose of underwriting, administration, claims processing and the enrolment of myself and my dependents in my Employer's/Policyholder's group insurance plan. In addition, **I UNDERSTAND** that personal information may be subject to disclosure to those authorized under the applicable laws within or outside of Canada.

If my Social Insurance Number is used as my certificate number, **I AUTHORIZE** its use for the administration of my group insurance plan.

**I AUTHORIZE** my Employer/Policyholder to make the required salary deductions for my group insurance plan.

If I enrol in direct deposit, **I AUTHORIZE** Industrial Alliance to deposit in my bank account, using the banking information I have provided in section 1, any amounts payable in regards to a claim that I submit under my group insurance plan. **I AGREE** that this authorization will apply until such time as I submit a written request to the contrary to Industrial Alliance. **I UNDERSTAND** that Industrial Alliance will have no further obligation with regard to the claims paid. **I ALSO UNDERSTAND** that Industrial Alliance can, without prior notice, terminate the direct deposit of my claims payments. This authorization takes effect on the date indicated below and will be valid for all other active bank accounts at this or any other financial institution that I may name in the future.

**I AGREE** that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Plan member's signature \_\_\_\_\_

Date

Y M D

## DISCLOSURE

At Industrial Alliance, the personal information we collect concerning you and your dependents is kept in strict confidence and is only used for the purposes you have authorized. Your personal file will be kept at Industrial Alliance's offices.

You have the right to request access to your personal information and, if necessary, correct any inaccurate information. In order to do so, send a written request to the following: Industrial Alliance Insurance and Financial Services Inc., Information Access Officer, 1080 Grande Allée West, PO Box 1907, Station Terminus, Quebec City, Quebec, G1K 7M3.

Access to your personal information will be limited to Industrial Alliance's employees, agents, reinsurers and service providers in the performance of their jobs, individuals to whom you have granted access, and persons authorized by law.

For the purposes of audits and administrative reporting, Industrial Alliance may release to your Employer/Policyholder statistical financial information without personal identifiers.





## Confidentiality Disclosure

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1. I acknowledge that my employment with Savanna Well Servicing Inc. ("Savanna") permits me access to trade secrets, knowledge, files, marketing information, pricing and information about the Company that is confidential ("Confidential Information"). I also acknowledge that as an employee of Savanna, I operate in a position of trust and have a fiduciary relationship with the Company. Based on my terms of employment, I agree not to disclose to anyone outside Savanna, any Confidential Information. I also agree that all Confidential Information acquired or disclosed to me by Savanna or any affiliate or related companies, or their corporate share holders, officers, directors, servants or agents relating to the processes, practices, methods, products, inventions, marketing plans, improvements, developments, suppliers, customers, trade secrets, technical designs, internal organization, personnel or finances of Savanna shall be held in strict confidence. I will not disclose any Confidential Information for my personal benefit or for the benefit of any other person, firm or corporation outside Savanna.
2. I agree that all Confidential Information including notes, memoranda, records, (electronic or otherwise) and writings made by me in respect of the business of Savanna shall be and remain the property of the Company and shall be delivered by me to Savanna forthwith upon request and upon cessation of my employment.
3. I agree that all worldwide rights, title and interest in all inventions, designs, drawings, patent and copyright works (including computer programs), trade secrets, discoveries, know-how and other intellectual property (whether registered or not) produced, made, composed, written, performed or designed by me, either alone or jointly with others, in the course of my employment with Savanna and in any way related to the business of Savanna, shall vest in and be the exclusive property of Savanna.
4. I agree both during and following the termination of my employment with Savanna to fully and promptly disclose to the Company, complete details of any invention, discovery, design or other intellectual property developed during my employment, with the intention that Savanna shall have full knowledge of the working and practical application of such rights and, at the expense of Savanna, I agree to co-operate in executing all necessary deeds and documents and all such other acts and things as may reasonably be required to vest such rights in the Company.
5. I acknowledge and agree that during my employment with Savanna, either as employee or consultant, I will be encouraged to maintain working relationships with the Company's clients and suppliers, and that:



## Confidentiality Disclosure

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- a. The transfer of confidential knowledge of Savanna's affairs to a client or supplier would be detrimental to the Company's interests; and
- b. Knowledge of the Company's affairs as well as knowledge of its clients and suppliers could irreparably damage the Company's interests if made available to a competitor or if used for competitive purposes.

Accordingly, I agree that I will not enter into or participate, directly or indirectly, in any business, which may conflict with technologies developed or being developed by Savanna during my period of employment or engagement as a consultant with Savanna Well Servicing Corp.

<b>Employee Name:</b> (please print)	
<b>Employee Signature:</b>	
<b>Date:</b>	
<b>Witness Name:</b> (please print)	
<b>Witness Signature:</b>	

*Please complete and return to your Crew Coordinator and/or HR Representative*

This acknowledgment pertains to the following corporate policies of Total Energy Services Inc. that are applicable to its employees and those of its Canadian subsidiaries, Savanna Drilling Corp., Savanna Well Servicing Inc., Total Oilfield Rentals Ltd., Opsco Process Corp., and Bidell Gas Compression Ltd.

I acknowledge receipt of the following corporate policies:

- ☒ **Code of Business Conduct (Dated March 7, 2024)**
- ☒ **Alcohol and Drug Policy (Dated November 30, 2023)**
- ☒ **Disclosure Policy and Procedures (Dated March 9, 2023)**
- ☒ **Information Technology Use Policy (Dated November 30, 2023)**
- ☒ **Benefits Eligibility (Dated November 15, 2024)**
- ☒ **HSE Policy (Dated January 1, 2024)**
- ☒ **Prevention of Workplace Harassment and Violence Policy (Dated August 1, 2022)**
- ☒ **Whistleblower Policy (Dated March 7, 2024)**
- ☒ **Savanna Company Provided Accommodation Policy - field only (Dated 2016)**

I understand that it is my responsibility to (1) read the above policies; (2) seek answers to any part of any policy I do not understand and (3) comply with these policies. I understand that a failure to comply with any of these policies could result in disciplinary action up to and including termination of employment. By signing this acknowledgment, I confirm that I have read and understand the contents, requirements, and expectations of the policies and agree to comply with the same as a condition of my continuing employment.

In addition, I understand that the addition of, or amendments to such policies may be made at any time by the management of Total Energy Services Inc. as specific circumstances warrant.

I further understand that these policies are available for me to read and reference at any time on Savanna's website under the following link: <https://www.savannaenergy.com/canada-well-servicing/>

Full Name (Please Print)

Signature

Date

November 15, 2024

SCHEDULE A

ACKNOWLEDGEMENT OF ALCOHOL AND DRUG POLICY, AGREEMENT TO SUBMIT TO REASONABLE  
CAUSE SUBSTANCE TESTING AND AGREEMENT TO RELEASE TEST RESULTS

I, \_\_\_\_\_, understand that SAVANNA WELL SERVICING (the "Company") maintains an Alcohol and Drug Policy (as amended from time to time, the "Policy") requiring all employees to report to work free from impairment from alcohol and drugs. I acknowledge that I have received and read a copy of the Policy. If I did not understand the Policy, I have asked for and have received an explanation. I understand that I am required to review and adhere to any updates or amendments to the Policy and that any breach of the Policy will result in disciplinary measures, up to and including termination of my employment for cause.

I also understand that as a condition of my continued employment, where the circumstances requiring testing outlined in the Policy exist, the Company will require me to undergo testing for the presence of alcohol or drugs and I hereby consent and agree to submit to such testing.

I further consent to the collection, use and disclosure of my Personal Information (as defined below) by the Company pursuant to Policy, and consistent with applicable Provincial and Federal privacy laws. I understand that "Personal Information" when used in this acknowledgement refers to information about me as an identifiable individual. I further understand that my Personal Information will contain my personal health information collected by the Company for the purposes of enforcing the Policy, including the results of any substance testing results being released only to those authorized Company Employees who need to know in order to act on the confidential results.

I also understand and agree that if I wish to take prescribed or otherwise legally authorized medications, including without limit, medical cannabis, I am required to provide certain documentation to the Company, which may include my proper prescription/authorization, purchase from a licensed facility and doctor's authorization stating any limitations to my fitness for duty as a result of such medications.

I also understand and agree that I am responsible for voluntarily disclosing any substance use disorder that I may have involving drugs or alcohol, including the inappropriate use of medication, to my supervisor and/or manager. In the event I suffer from a substance use disorder, I agree to participate in a rehabilitation or substance abuse treatment program (the "Treatment Program") prior to returning to active duty. I further consent to the disclosure of such Personal Information of mine by the Treatment Program as is necessary for the Company to confirm my ongoing participation in, and successful completion of, such Treatment Program.

THIS AGREEMENT SIGNED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, in the City of

\_\_\_\_\_, in the Province of \_\_\_\_\_.

Signature \_\_\_\_\_

Print Name: \_\_\_\_\_

Witness Signature \_\_\_\_\_

Witness Name: \_\_\_\_\_



# ALCOHOL & DRUG POLICY HIGHLIGHTS

## What is the purpose of this policy?

Savanna is committed to the health, safety, and wellness of our employees, contractors, and the public. The use of illegal drugs, medication, or alcohol can have serious impacts in the workplace. This policy outlines the requirements for workers to be fit for duty, to maintain a safe work environment.

## Where can you find this policy?

You may access the policy by scanning the QR code, or by visiting the following websites.

**Savnet:** <http://sesc-vmssp2010/Pages/welcome.aspx> (go to: Policies, Procedures & Forms > HSE > Policy)

**Employee Portal:** <https://www.savannaenergy.com/canada-well-servicing>

SCAN ME






## What is your responsibility as an employee?

- ☒ Report to work fit for duty for all scheduled, on-call, and standby work.  
Remain fit for duty while on-call or standby and while on company business or company worksites.
- ☒ Immediately inform your supervisor or HR representative, if you reasonably believe that another worker may be unfit for duty, including alcohol or drug use prior to starting or continuing any work. This includes the use, sale, or distribution of alcohol or drugs at the worksite (*including company-paid accommodation*).
- ☒ **Before starting work**, you must inform your supervisor if you are using medication that could cause of unsafe side effects. More information regarding medication is included in the next section, below.
- ☒ If you might have a substance abuse disorder, you must disclose this to your supervisor and seek assistance **prior to any incident**. Prevention and early identification is important, and Savanna will take reasonable steps to accommodate in accordance with applicable law and this policy.
- ☒ Employees are required to notify their supervisor and/or Operations leader(s) in the event of any charge or conviction in relation to an Alcohol or Drug-related offense under the Criminal Code of Canada and any other statute or regulation that may have the potential to adversely affect their job performance or responsibilities. Including the inability to operate company or commercial vehicles.

## What if you are on medication?

If you are on medication that could affect your ability to work safely, you must:

-  **Before performing any work**, provide written confirmation from your prescribing physician, regarding your fitness for duty. If more information is needed, contact Savanna's Human Resources team ([swsca-humanresources@savannawellservicing.com](mailto:swsca-humanresources@savannawellservicing.com)).
-  **Use the medication as directed by your doctor**, and only for the condition(s) in which the medication was prescribed.
-  Obtain your medication from a pharmacy or a place approved by Health Canada.



**REMEMBER: STOP, THINK, ACT**

**STOP:** When something doesn't feel right.

**THINK:** What could go wrong and how bad could it be?

**ACT:** Reduce the risk and make it safe. Refuse unsafe work.



# Retirement Savings Plan (RSP) Non-Registered Savings Plan (NREG) enrolment form

Return the completed form to:

Sun Life Financial, Group Retirement Services

PO Box 2025 Stn Waterloo, Waterloo ON N2J 0B4

[www.sunlife.ca](http://www.sunlife.ca)

**Important:** Detach and maintain the Declaration of Trust for your records.

Nota : La version française de ce document est également disponible.

Please PRINT clearly.

## Account type

Indicate the product(s) you wish to enrol in and complete the applicable sections on this enrolment form.

<input type="checkbox"/> RSP contract number	<b>93895-G</b>	You will be the owner and the annuitant of the account. Complete sections 2, 3, 4, 5, 7, 8 and 9. Section 6 is optional. Note: If you wish to make contributions to a Spousal RSP, you and your spouse must complete a Spousal RSP Enrolment form.
<input type="checkbox"/> NREG contract number	<b>93896-G</b>	Complete sections 2, 4, 5, 7, 8 and 9. Section 6 is optional.

## Retirement Savings Plan (RSP) Application (Sections 1 to 3 are for registration purposes)

### 1 Plan sponsor information

This information is to be completed by the plan sponsor.

Note: The term "plan sponsor" includes any participating affiliates designated by the plan sponsor.

Name of plan sponsor <b>Total Energy Services Inc.</b>	Client ID <b>C00IC</b>	Plan <b>01</b>	Contract number <b>93895 -G</b>
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#### Classifications

Subdivision <b>001</b>	Payroll ID <input type="checkbox"/> 001 – Total Energy Corporate Office <input type="checkbox"/> 007 – Spectrum Process Systems Inc. <input type="checkbox"/> 204 – Savanna Drilling <input type="checkbox"/> 002 – Bidell Gas Compression Ltd. <input checked="" type="checkbox"/> 206 – Savanna Well Servicing <input type="checkbox"/> 004 – Total Oilfield Rentals Ltd.	User field <b>N/A</b>
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### 2 Owner information

Note: The term "owner" has the same meaning as the term "annuitant" in subsection 146(l) of the Income Tax Act (Canada).

First name	Middle initial	Last name	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of birth (dd-mm-yyyy)	Social Insurance Number*	Identification number** (Employee ID)	
Address (street number and name)			Apartment or suite
City	Province	Postal code	Telephone number (day)
Email address			Telephone number (evening)

\*By submitting this form you authorize your Social Insurance Number (SIN) to be used for the purposes of tax reporting and administration of benefits and where applicable, you also authorize the use of your SIN as your identification number until such time as it is replaced with a number that is not your SIN.

\*\* For the purpose of completing this form your Identification number is your Employee number.

ENRLMNT



### 3 Your application for Retirement Savings Plan (RSP)

I apply for a RSP (the “Plan”), to be established under the terms of the Sun Life Financial Trust Inc. Group Retirement Savings Plan Declaration of Trust, a copy of which I have received with this application.

I request that Sun Life Financial Trust Inc. (the “Trustee”) apply for the registration of this Plan as a registered retirement savings plan (RRSP) under the Income Tax Act (Canada) and any applicable provincial legislation.

I appoint the plan sponsor named in this Application to act as my agent for the purpose of the Plan, including payroll deductions, if applicable.

I agree to be bound by the terms and conditions of the Declaration of Trust and, if applicable, any locking-in addendum.

Owner signature X	Date (dd-mm-yyyy)
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#### Administration information

### 4 Employment information

Date of enrolment (dd-mm-yyyy)	Date of employment (dd-mm-yyyy)
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(Leave Section 4 blank, Benefits Team will enter info)

## 5 Beneficiary designation\*

\*If you live in Alberta, British Columbia, Manitoba, Newfoundland and Labrador, N.W.T., Nunavut, Quebec, Saskatchewan or Yukon Territory, and you allocate your NREG contributions to Total Energy Stock Fund payments derived from these funds will be made to your estate upon death.

\*If you live in Quebec, death benefits from your RSP will be made to your estate.

Complete this section to designate a beneficiary for your account. In the absence of a beneficiary designation, and if not payable to your spouse as prescribed by law, death benefits will be paid to your estate.

Caution in all provinces except Quebec: Your designation of a beneficiary will not be changed or revoked automatically by any future marriage or divorce. Should you wish to change or revoke your beneficiary in the event of a future marriage or divorce, you have to make a new designation. In Quebec, a divorce granted after December 1<sup>st</sup>, 1982 cancels the beneficiary designation of the married spouse.

In Quebec if you name more than one beneficiary and give them unequal shares of the benefit and one of them dies, the deceased beneficiary's share will default to contingent beneficiary or estate rather than being divided amongst the other beneficiaries.

**Note:** To appoint a trustee for a beneficiary who is a minor, please complete the 'Appointment of trustee for a minor beneficiary' form. In Quebec, any amount payable to a minor beneficiary during his/her minority will be paid to the parent(s) or legal guardian on his/her behalf.

If you have a spouse when you die, the law may stipulate that all or part of the death benefit be paid to your qualifying spouse, unless your spouse waives the death benefit. A beneficiary designation other than your spouse would only apply to those death benefits which are not, according to the law, payable to your surviving spouse. If you wish your spouse to receive all benefits, please ensure you designate your spouse as beneficiary in the space below.

I revoke any previous beneficiary designations and name as beneficiary for benefits due on my death:

<input type="checkbox"/> RSP <input type="checkbox"/> NREG	Beneficiary's first name	Middle initial	Last name	
Relationship to you**		<input type="checkbox"/> Revocable***	Date of birth (dd-mm-yyyy)	Percentage of benefits %
<input type="checkbox"/> RSP <input type="checkbox"/> NREG	Beneficiary's first name	Middle initial	Last name	
Relationship to you**		<input type="checkbox"/> Revocable***	Date of birth (dd-mm-yyyy)	Percentage of benefits %
<input type="checkbox"/> RSP <input type="checkbox"/> NREG	Beneficiary's first name	Middle initial	Last name	
Relationship to you**		<input type="checkbox"/> Revocable***	Date of birth (dd-mm-yyyy)	Percentage of benefits %

\*\*Following are the values to be used for relationship

Husband (married)	Wife (married)	Civil union	Common-law	
Fiancé(e)	Friend	Former spouse	Father	Mother
Brother	Sister	Son	Daughter	Nephew
Niece	Aunt	Uncle	Cousin	Grandchild
Grandparent	Step family	Family-in-law	Institution	Other

\*\*\*Where Quebec law applies, a **married or civil union spouse** beneficiary is **irrevocable** unless you indicate otherwise. To avoid this restriction and make your legal spouse designation revocable, you must check the revocable box above.

If your beneficiary is irrevocable, you may not change your beneficiary designation and may not be able to withdraw/transfer your assets out of the plan unless you provide Sun Life Financial with the irrevocable beneficiary's written consent.



## 6 Contingent beneficiary designation (not valid in the province of Quebec)

Complete this section to appoint a contingent (secondary) beneficiary for your account.

If there is no surviving beneficiary at the time of my death, I declare that the following contingent beneficiary shall receive all benefits due on my death in accordance with any applicable legislation. If there is no surviving contingent beneficiary at the time of my death, the proceeds shall be paid to my estate.

I revoke all previous contingent beneficiary appointments.

<input type="checkbox"/> RSP <input type="checkbox"/> NREG	Beneficiary's first name	Middle initial	Last name
Relationship to you** (refer to above values)		Date of birth (dd-mm-yyyy)	Percentage of benefits %
<input type="checkbox"/> RSP <input type="checkbox"/> NREG	Beneficiary's first name	Middle initial	Last name
Relationship to you** (refer to above values)		Date of birth (dd-mm-yyyy)	Percentage of benefits %
<input type="checkbox"/> RSP <input type="checkbox"/> NREG	Beneficiary's first name	Middle initial	Last name
Relationship to you** (refer to above values)		Date of birth (dd-mm-yyyy)	Percentage of benefits %

## 7 Contributions

Note: You can only direct your contributions to either the RSP or the NREG, not both products.

### RSP member contributions

I authorize my employer to deduct \_\_\_\_\_ % (whole percentages only) per pay to be deposited into my RSP.

Note: Any amount over eligible percentage will go to voluntary contributions.

Please select Option A, B or C to allocate your contribution amount.

☐ Option A – Allocate 100% of the amount deducted from my pay to my RSP

☐ Option B – Split contribution between member and spousal RSP

\_\_\_\_\_ % of the total payroll deduction amount to my RSP plus

\_\_\_\_\_ % of the total payroll deduction amount to my Spousal RSP

*The total of the two percentages entered in Option B must equal 100%*

☐ Option C – Allocate 100% of the amount deducted from my pay to my Spousal RSP

OR

### NREG contributions

I authorize my employer to deduct \_\_\_\_\_ % per pay to be deposited into the plan.

Note: That any amount over eligible percentage contributions will go to voluntary.

### Employer contributions

Select the product you wish to allocate your employer contributions.

☐ Registered Retirement Savings Plan (RRSP)

☐ Non Registered Savings Plan (NREG)

When you enrol,

Years of (continuous) participation on the plan	Your matching contribution	Your employer's matching contribution
1	2.0%	1.50%
2	3.0%	2.25%
3	4.0%	3.00%
4	5.0%	3.75%
5 or more	6.0%	4.50%

**\*\*NOTE\*\*:** 100% of the Employer Contribution will go towards your selection

## 8 Investment instructions

Choose funds from one or more of the following investment approaches.

Percentages must be in whole numbers and total 100%.

I request Sun Life Assurance Company of Canada to allocate contributions to the plan as follows. This instruction applies to all future contributions.

\*ALL Employer contributions will be directed 100% to the Total Energy Stock Fund.

### Help me do it - target date funds

Pick the target date fund closest to when you will need your money.

	RRSP member allocation	NREG member allocation
BLK LP Index Retirement (QNB)	%	%
BLK LP Index 2025 Fund (QNS)	%	%
BLK LP Index 2030 Fund (QNE)	%	%
BLK LP Index 2035 Fund (QNT)	%	%
BLK LP Index 2040 Fund (QNF)	%	%
BLK LP Index 2045 Fund (QOP)	%	%
BLK LP Index 2050 Fund (QSZ)	%	%
BLK LP Index 2055 Fund (QYP)	%	%
BLK LP Index 2060 Fund (QJO)	%	%

### Let me do it

Pick from any of the funds listed on this form to build your own portfolio that matches your Investment Risk Profile.

	RRSP member allocation	NREG member allocation
SLA 1Yr Guaranteed Fund (012)	%	%
SLA 3Yr Guaranteed Fund (036)	%	%
SLA 5Yr Guaranteed Fund (060)	%	%
SLF Money Market (X21)	%	%
PH&N Bond Fund (U44)	%	%
TDAM Cdn Bond Index Fund (X37)	%	%
B.G. Balanced Fund (U07)	%	%
Invesco Income Growth C (X23)	%	%
B.G. Canadian Equity (U05)	%	%
Fidelity True North Fund (X56)	%	%
SL Dynamic Equity Income (QTO)	%	%
Total Energy Serv Stock (A5V)	%	%
BG American Equity (U21)	%	%
BLK EAFE Equity Index (W45)	%	%
Invesco Global R E Listed (QRY)	%	%
Invesco Global Small Cap (QVC)	%	%
MFS Intl Equity (QON)	%	%
TDAM US Mkt Index Fund (X40)	%	%
<b>Total</b>	<b>100 %</b>	<b>100 %</b>

If the total % does not equal 100%, or if this information is not completed, Sun Life Assurance Company of Canada reserves the right to invest the difference/total in the default fund chosen for the plan by your plan sponsor, which is the BLK LP Index Fund closest to without exceeding your 65<sup>th</sup> birthday.

## 9 Your authorization and signature

I require that all future communications, including this application and Group Plan documents, be provided in English.

I understand that for contributions invested in Total Energy Stock Fund, the terms and conditions set out in the Custodial Agreement between the Custodian and my plan sponsor apply.

I understand that for contributions invested in segregated funds or guaranteed funds, the terms and conditions set out in the Group Annuity Policy issued to my plan sponsor by Sun Life Assurance Company of Canada apply.

I acknowledge that by enrolling in this plan, I am bound by the terms of the group savings plan contract\* between my plan sponsor and Sun Life Financial Trust Inc., the applicable details of which have been or will be provided or made available to me by Sun Life Financial Trust Inc. or my plan sponsor as part of the enrolment process.

I understand that the funds available in my plan are offered under a group savings plan contract issued to my plan sponsor by Sun Life Financial Trust Inc.

I authorize Sun Life Financial Trust Inc., its agent, Sun Life Assurance Company of Canada, and their agents and service providers, to collect, use and disclose to my plan sponsor, its agents and service providers, my personal information, which may include annual income information, for the purpose of plan administration.

I also authorize Sun Life Financial Trust Inc., its agent, Sun Life Assurance Company of Canada, and their agents and service providers to disclose my personal information to the advisor appointed by my plan sponsor, if any, or to my personal advisor for the purpose of enabling in-plan advisory services.

\* Group savings plan contract includes a group annuity policy issued by Sun Life.

Unless I select 'No' below, I agree that my information may be collected, used and shared with the members of the Sun Life Financial group of companies\*\*, their agents and service providers to inform me of other financial products and services that they believe meet my changing needs.

☐ No, I refuse permission.

\*\*The companies in the Sun Life Financial group of companies mean only those companies identified in Sun Life Financial's Privacy Policy for Canada which is available on the Sun Life Financial website, [www.sunlife.ca](http://www.sunlife.ca).

Owner Signature

X

Date (dd-mm-yyyy)

## 10 Respecting your privacy

Respecting your privacy is a priority for the Sun Life group of companies. We keep in confidence personal information about you and the products and services you have with us to provide you with investment, retirement and insurance products and services to help you meet your lifetime financial objectives. To meet these objectives, we collect, use and disclose your personal information for purposes that include: underwriting; administration; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; and we may tell you about other related products and services that we believe meet your changing needs.

The only people who have access to your personal information are our employees, distribution partners such as advisors, and third-party service providers, along with our reinsurers. We will also provide access to anyone else you authorize. Sometimes, unless we are otherwise prohibited, these people may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You can ask for the information in our files about you and, if necessary, ask us in writing to correct it. To find out more about our privacy practices, visit [www.sunlife.ca/privacy](http://www.sunlife.ca/privacy).

Group Retirement Services are provided by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.



## Employee Referral Bonus Program Form

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Referring Employee's Name	Referring Employee's Division and Position
Referred Applicant's Name	Referred Applicant's Division and Position ( <i>HR Use Only</i> )
Date Submitted	Briefly describe how the referred employee is known to you
"Hot Job" Eligible? (circle one)	<input type="checkbox"/> <u>YES</u> <input type="checkbox"/> <u>NO</u>

**Please note:** Referral Forms must be sent to your Crew Coordinator for verification.

Your Crew Coordinator will send all completed submission requests to Human Resources via e-mail to: [SWSCA-HumanResources@savannawellservicing.com](mailto:SWSCA-HumanResources@savannawellservicing.com) which must be accompanied by the referred employees' resume.

For e-mail submissions, please enter "Employee Referral - [Enter Referred Employee's Name]" in the subject line.

(For example, "Employee Referral - John Smith")

Referrals are subject to the terms and conditions of the Employee Referral Program. This policy is available on Savnet or through your HR Representative.

Any submission requests will be paid out within thirty (30) days of the referred employee completing the payment eligibility requirements.

If you may have any inquiries about this program, you may send an e-mail to: [SWSCA-HumanResources@savannawellservicing.com](mailto:SWSCA-HumanResources@savannawellservicing.com)

Crew Coordinator Name and Signature	Date
HR Manager Name and Signature	Date