

Shared Risk Plan for Certain Bargaining Employees of New Brunswick Hospitals
 Shared Risk Plan for CUPE Employees of New Brunswick Hospitals

APPLICATION FOR MEMBERSHIP

EMPLOYER INFORMATION

EMPLOYER:

EMPLOYEE INFORMATION

NAME:

PLAN: Shared Risk Plan for Certain Bargaining Employees of New Brunswick Hospitals
 Shared Risk Plan for CUPE Employees of New Brunswick Hospitals

SOCIAL INSURANCE NO. - -	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	LANGUAGE <input type="checkbox"/> English <input type="checkbox"/> French
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DATE OF BIRTH ____/____/____ Year Month Day	DATE OF HIRE ____/____/____ Year Month Day	DATE OF MEMBERSHIP ____/____/____ Year Month Day
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Full-Time Employee (As defined in Collective Agreement)
 Part-Time Employee (As defined in Collective Agreement) - _____% of Full-Time
 Other (Casual, temporary, etc.)

BENEFICIARY INFORMATION

NAME:

ADDRESS:

DATE OF BIRTH ____/____/____ Year Month Day	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	RELATIONSHIP
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I hereby appoint the above-named beneficiary (beneficiaries) for any amount payable after my death in accordance with the terms of the Plan indicated above and I reserve the right to change my appointment of beneficiary so far as it is legally permissible to do so.

Note: If you have a spouse or common-law partner as defined in the *Pension Benefits Act*, your spouse or common-law partner is your beneficiary, except where your spouse or common-law partner has waived their rights (fully or partially) by signing a “Pre-retirement Death Benefit Waiver” form (Form 9 of the *Pension Benefits Act*). The waiver form can be signed at any time prior to your death.

If my spouse or common-law partner (who has not completed a valid “Pre-retirement Death Benefit Waiver” form) dies before me, or if I do not have a spouse or common-law partner, if any beneficiary named above dies before me, the interest of such beneficiary shall, unless otherwise provided above, accrue to the surviving beneficiary (beneficiaries) or, if none, to my estate.

AUTHORIZATION

I hereby apply for membership in the Plan indicated above and authorize my employer to deduct from my earnings any contributions required under the said Plan.

I hereby certify that the information shown on this application is correct to the best of my knowledge.

I understand that this information is collected for the purposes of administering the pension plan indicated above. By participating in this Plan, I consent to the collection and use of this information by my employer and its representatives and/or service providers in connection with the administration of the Plan.

SIGNATURE OF APPLICANT	DATE ____/____/____ Year Month Day
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SIGNATURE OF EMPLOYER	DATE ____/____/____ Year Month Day
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