

**RECIPROCAL TRANSFER AGREEMENT -
SHORTFALL PURCHASE APPLICATION FORM**



Between

The Pension Plan for Part-Time and Seasonal Employees of the Province of New Brunswick (the “Part-Time Plan”)
and

The Shared Risk Plan for CUPE Employees of New Brunswick Hospitals (the “CUPE Hospitals Shared Risk Plan”)

PLEASE NOTE: This application will only be processed by Vestcor once the initial transfer of the applicant’s assets from the Part-Time Plan to the CUPE Hospitals Shared Risk Plan has been completed.

Section 1 - To be Completed by the Applicant

First Name: _____ Last Name: _____

SIN (optional): _____ / _____ / _____ Vestcor Reference Number: _____ OR Employee ID Number: _____

Date of Birth: _____ / _____ / _____ Correspondence Requested In: English French
Day Month Year

Are you retiring? Yes* No If yes, indicate retirement date: _____ / _____ / _____ *priority will be given to your application
Day Month Year

Address: _____

Approximate Date when Initial Transfer was completed: _____ / _____ / _____ Employer: _____
Day Month Year

PRIVACY CONSENT: *The personal information collected on this form will be used by Vestcor to: identify the employee making the request and the employer; determine language preference; confirm employment history and pension plan participation; determine eligibility, the cost to purchase the shortfall, and the shortfall service that would be credited; contact the employee or employer as necessary; and ultimately ensure that the pension plan is administered in accordance with the pension plan’s governing documents and applicable legislation. The information may be disclosed to the Canada Revenue Agency as required by law. If you have any questions about the collection and use of this information, contact Vestcor’s Member Services team, by mail at P.O. Box 6000, Fredericton, NB, E3B 5H1, by phone at (506) 453-2296 or 1-800-561-4012, or by email at info@vestcor.org. In addition, please note that Vestcor’s Privacy Statement is available at www.vestcor.org/privacy.*

AUTHORIZATION: *I certify that the information above is accurate.*

Signature: _____ Date: _____ / _____ / _____
Day Month Year

Section 2 - To be Completed by the Employer

Date Joined Exporting Plan: _____ / _____ / _____ Date Joined Importing Plan: _____ / _____ / _____
(the Part-Time Plan) Day Month Year (the CUPE Hospitals SRP) Day Month Year

Full-Time Bi-Weekly Salary at Date of Shortfall Purchase Application: _____

In order to determine the total amount of shortfall service which can be purchased by the applicant under the CUPE Hospitals Shared Risk Plan, Vestcor will require the following documentation from the Employer (please provide in electronic format if available):

Withholding Report (if available) or Report of Bi-weekly Earnings for period of Applicant’s participation in the Part-Time Plan; and

Full-Time Bi-weekly Salary Schedule for period of Applicant’s participation in the Part-Time Plan

Employer Signature _____ Date: _____ / _____ / _____
Day Month Year

Please return completed form as soon as possible to:
Vestcor
P.O. Box 6000, Fredericton, NB E3B 5H1
Fax: 506-457-7388

For more information, please contact Vestcor at:
Telephone: 506-453-2296 or 1-800-561-4012 (toll free)
Email: info@vestcor.org
Website: vestcor.org

IMPORTANT: Information submitted via email is not considered secure unless encrypted. If you would like to submit this form via email and do not have a method to encrypt it, please contact our office in order to submit this form electronically in a secure format