VESTCOR

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	LANGUAGE
- -	☐ Male ☐ Female	☐ English ☐ French
DATE OF BIRTH _____ /____ /____ Year Month Day	**DATE OF HIRE** _____ /____ /____ Year Month Day	**DATE OF MEMBERSHIP** _____ /____ /____ Year Month Day

☐ **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	SEX	RELATIONSHIP
_____ /____ /____ Year Month Day	☐ Male ☐ Female	

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
SIGNATURE OF EMPLOYER	**DATE** _____ /____ /____ Year Month Day

Please forward completed form to: **Vestcor Pension Services Corporation**
P.O. Box 6000
Fredericton, NB E3B 5H1