BC NURSES' UNION
Standing up for health care

HSA

NBA RETIREE BENEFIT PROGRAM
APPLICATION FORM

PERSONAL INFORMATION		
Last Name (AS IT APPEARS ON PENSION STATEMENT):	**First N**ame (AS IT APPEARS ON PENSION STATEMENT):	Middle Initial:
Name at date of retirement, if different from above:		
Address:		
City:	Province:	Postal Code:
Home Phone: Cell Phone:	E-mail Address (Optional):	
Date of birth (mm/dd/yyyy):	Social Insurance Number (SIN):	

EMPLOYMENT INFORMATION	
Employer at retirement:	Worksite at retirement:
Date of Retirement (mm/dd/yyyy):	Union at retirement: ☐ BCNU ☐ HSA ☐ UPN

PENSION INFORMATION
I pay part or all of the premiums for: ☐ MSP ☐ Extended Health ☐ Dental

I am a member of: ☐ Municipal Pension Plan (MPP)	☐ Public Service Pension Plan (PSPP)	☐ Canadian Blood Services Pension Plan (CBS)
And as a member of MPP, my Pensionable service is - ☐ Under 2 years ☐ 2 years – Under 5 years ☐ 5 years or more	And as a member of PSPP. my Pensionable service is – ☐ Under 2 years ☐ 2 years –under 4 years ☐ 4 years-under 6 years ☐ 6 years-under 8 years ☐ 8 years-under 10 years ☐ 10 years or more	

STATUTORY DECLARATION AND AUTHORIZATION

I, _____ [Full Name], DO SOLEMNLY DECLARE that the information on the application form is true and accurate and that I believe that I am eligible to receive benefits under the Retiree Benefit Program (RBP).

I further acknowledge and agree that, should I receive the Benefit from the RBP and it is later discovered that I was not entitled to receive the Benefit or any portion of the Benefit, I will fully reimburse the RBP for any such overpayment I receive and that I will indemnify and save harmless RBP from and against all liabilities, losses, costs, fines, penalties, charges, legal costs and expenses reasonably incurred by the RBP in respect of any proceeding in any way caused by or arising, directly or indirectly, from or in consequence of, any matter relating to my receiving any Benefit that I am not entitled to receive, including any proceeding the RBP might bring against me in order to collect the amount of any overpayment.

I make this solemn declaration, conscientiously believing it to be true and knowing it is of the same force and effect as if made under oath.

DECLARED BEFORE ME at the City of _____, in the Province of _____, this _____ day of _____, 20____.

_____

A Notary Public or Commissioner
NAME:

_____

RETIREE NAME:

PLEASE COMPLETE THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC OR COMMISSIONER FOR TAKING AFFIDAVITS AND SEND THIS FORM TO: **RBP Committee, 4060 Regent Street, Burnaby, BC, V5C 6P5**.

For members of the Municipal Pension Plan and Public Service Pension Plan: In order to verify information of members, BCNU on behalf of the RBP will need to share personal information you provide as part of this application, (including your Social Insurance Number), with the British Columbia Pension Corporation who in turn can confirm whether you have been paying your share of MSP premiums for which you will be seeking to receive the Benefit. Your Social Insurance Number will also be used to report Benefit amounts that are taxable.

CONSENT

I give my consent to the BCNU on behalf of the RBP to disclose my name, address and social insurance number to the British Columbia Pension Corporation in order to permit the RBP to consider my continuing eligibility for this benefit. I also give my consent to the British Columbia Pension Corporation to disclose my group benefit plan premium information to the BCNU on behalf of the RBP to verify that I am entitled to receive this benefit and for the RBP to administer this Benefit. My consent to disclose this information continues until such time as I revoke my consent in writing.

_____ _____

Signature Date

DIRECT DEPOSIT AUTHORIZATION
(FOR RETIREES)

British Columbia Nurses' Union
4060 Regent Street
Burnaby, BC V5C 6P5

Web: www.bcnu.org

Tel : 604-433-2268 (local)
800-663-9991 (toll-free)
Fax: 604-433-7945 (local)
888-284-2222 (toll-free)

INSTRUCTIONS

- Complete this form to initiate or change direct pay deposits.
- Attach either a personal cheque for chequing account or complete the banking information section.
- Notify BC Nurses' Union ***before*** changing or closing your bank account (changing or closing your bank account before notifying BC Nurses' Union could result in payment not being made to your account).
- Submit completed form to BC Nurses' Union.

LAST NAME	FIRST NAME

I hereby authorize and request the BC Nurses' Union to make direct deposits to my account as indicated below

check (√) if applicable	BANKING INFORMATION			
☐ NEW ☐ CHEQUING ☐ CHANGE ☐ SAVINGS	INSTITUTION NO.	TRANSIT NO. (must be 5 digits)	BANK ACCOUNT NO.	EFFECTIVE DATE (YYYY/MM/DD)

SIGNATURE	DATE SIGNED (YYYY/MM/DD)

BANK OR OTHER FINANCIAL INSTITUTION VERIFICATION Not required if encoded deposit slip or voided cheque attached. Signature or bank domicile stamp confirming accuracy of transit and account number and authenticity of account signature	DATE SIGNED (YYYY/MM/DD)	BANK OR FINANCIAL INSTITUTION ADDRESS

BCNU USE ONLY

ENTERED INTO PAY SYSTEM BY	DATE (YYYY/MM/DD)	CHECKED BY	DATE (YYYY/MM/DD)

Return original to BC Nurses' Union. If you wish to keep a copy for your records, please photocopy.