

**TELECOMMUNICATION WORKERS PENSION PLAN  
ELECTRONIC FUNDS TRANSFER REQUEST FORM**

Telephone: (604) 430-1317 • Facsimile (604) 430-5395

Bank Stamp

**Member's Name:**

**Member's Address:**

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**SECTION A: To Be Completed By Your Banking Institution**

Name of bank: \_\_\_\_\_

Inst. No.

Branch No.

Account No.

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Is this a joint account?

Yes

No

\_\_\_\_\_  
Signature of Financial Institution Official

\_\_\_\_\_  
Telephone No.

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**SECTION B: To Be Completed By You**

I hereby authorize the Trustees of the Telecommunication Workers Pension Plan ("the Plan") to deposit all pension payments due me under the terms of the Plan directly into the account named above.

I acknowledge that although no amounts may be payable to me or my estate by the Plan after my death, it is possible that direct deposits to my account may continue until the Plan is notified of my death and terminates the direct deposits. In consideration of the Plan agreeing to make direct deposits to my account, I hereby agree that:

1. Any monies directly deposited to my account after my death, which, under the terms of the Plan are not payable to my estate, are held in trust for the Plan and are to be repaid to the Plan forthwith;
2. The Administrator of the Plan is entitled to request from time to time satisfactory evidence that I am alive and therefore that pension benefits continue to be payable to me under the Plan. The Administrator may, in his/her discretion, discontinue the direct deposit of my pension payments and instead make payments by cheque until such evidence has been received by him/her; and
3. These agreements are binding upon me and upon my heirs, executors, administrators and personal representatives.

This authority will remain in effect until I have given the Plan written notice to terminate it. I understand that I must give the Plan enough notice to allow reasonable time to act on my instructions. In the event an overpayment should be credited to my account during or after my lifetime, I authorize the Plan to direct my banking institution to refund same to the Plan and charge such payment to my/our account.

**A JOINT ACCOUNT REQUIRES AN ADDITIONAL SIGNATURE**

\_\_\_\_\_  
YOUR SIGNATURE (RETIREE)

\_\_\_\_\_  
SIGNATURE OF JOINT ACCOUNT HOLDER

\_\_\_\_\_  
SOCIAL INSURANCE NUMBER

\_\_\_\_\_  
YOUR TELEPHONE NUMBER

\_\_\_\_\_  
DATE