

# RELEASE OF INFORMATION AUTHORIZATION

(FOR RETIRED MEMBER)

PENSION PLAN USE ONLY

PERSON ID

**WorkSafeBC Pension Plan**

PO Box 9460

Victoria BC V8W 9V8

Location 2995 Jutland Road, Victoria

Web [worksafebc.pensionsbc.ca](http://worksafebc.pensionsbc.ca)

Toll-free in Canada/U.S. 1 866 322-9277

Fax 250 953-0431

Email [Retired@pensionsbc.ca](mailto:Retired@pensionsbc.ca)**INSTRUCTIONS:**

- Complete this form to allow WorkSafeBC Pension Plan to disclose your pension information to the third party described below in part A.
- Sign and date this form and forward it to WorkSafeBC Pension Plan. Make a copy for your records.

**PART A – DIRECTION**

RETIRED MEMBER LAST NAME

FIRST AND MIDDLE NAME(S)

SOCIAL INSURANCE NO.

MAILING ADDRESS *(include Apt. No., if applicable)*

CITY/TOWN

PROVINCE

POSTAL CODE

HOME PHONE NO.

INDICATE PERSON/ORGANIZATION NAME(S) YOU AUTHORIZE TO RECEIVE THE INFORMATION

MAILING ADDRESS *(include Apt. No., if applicable)*

CITY/TOWN

PROVINCE

POSTAL CODE

PHONE NO.

DESCRIPTION OF INFORMATION TO BE DISCLOSED

DESCRIBE HOW DISCLOSED INFORMATION IS TO BE USED

**PART B – IMPORTANT INFORMATION ABOUT YOUR RIGHTS**

- I understand this authorization expires one year from the date signed below.
- This authorization is voluntary. I may revoke it at any time by contacting WorkSafeBC Pension Plan in writing.
- I may request a copy of the disclosed information.
- I have the right to require that the person or organization described above will not disclose this information to anyone else without my permission.

**PART C – AUTHORIZATION**

- I hereby authorize WorkSafeBC Pension Plan to disclose the pension information described in part A.
- I have read and I understand the rights described in part B.

RETIRED MEMBER SIGNATURE

DATE SIGNED *(authorization expires  
one year from date signed)*  
YYYY – MM – DD