WORK SAFE BC

RELEASE OF INFORMATION AUTHORIZATION

PERSON ID

WorkSafeBC Pension Plan
PO Box 9460
Victoria BC V8W 9V8
Location 2995 Jutland Road, Victoria
Web **worksafebc.pensionsbc.ca**

Toll-free in Canada/U.S. 1 888 440-0111
Fax 250 953-0433
Email **worksafebc@pensionsbc.ca**

INSTRUCTIONS:

- Complete this form to allow the WorkSafeBC Pension Plan to disclose your pension information to the third party described below in part A.
- This authorization is voluntary. You may revoke it at any time by contacting the pension plan in writing.
- Sign and date this form and forward it to the WorkSafeBC Pension Plan. Make a copy for your records.

PART A – DIRECTION

PLAN MEMBER LAST NAME	FIRST AND MIDDLE NAME(S)	EMPLOYEE NO.

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

CITY/TOWN	PROVINCE	POSTAL CODE	HOME PHONE NO. *(include ten digits)*

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

DESCRIPTION OF INFORMATION TO BE DISCLOSED

☐ RETIREMENT PLANNING ☐ SERVICE TRANSFER ☐ PURCHASE OF SERVICE ☐ REINSTATEMENT ☐ OTHER: _____

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.
- I may revoke this authorization before the expiration date by notifying the pension plan in writing. This decision will not affect any actions that the WorkSafeBC Pension Plan took prior to receiving my notice to revoke.
- I authorize the BC Pension Corporation to release my pension account information including salary and contribution data, and information regarding retirement planning, service transfers, purchase of service, reinstatements of service, and final payment of my pension to WorkSafeBC People Services Department in the Human Resources Division. I have the right to require that the person or organization described above will not disclose this information to anyone else without my permission.
- I may request a copy of the disclosed information.

PART C – AUTHORIZATION

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

PLAN MEMBER SIGNATURE

DATE SIGNED *(authorization expires one year from date below)*

YYYY – MM – DD

Freedom of Information and Protection of Privacy Act–The personal information on this form is collected under the authority of the *Workers Compensation Act* and will be used by the Pension Corporation to administer a plan member's pension and other non-pension benefits. If you have any questions about the collection and use of this information, contact the Privacy Officer at 2995 Jutland Road, Victoria BC V8T 5J9 or by telephone at 250 387-1002.

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Reset Form