

**U.S. DIRECT DEPOSIT
AUTHORIZATION**

PERSON ID

Instructions

- Take this form to your financial institution to verify your account information.
- Due to federal laws, and guidelines from the Financial Transactions and Reports Analysis Centre of Canada, all electronic funds transfer (EFT) payments sent to the U.S. require a member's complete physical address with a street number.
- It's important to keep your mailing address current as we regularly send newsletters and payment information to retired members or beneficiaries.
- Please type or print clearly and submit your completed form to the WorkSafeBC Pension Plan.

WorkSafeBC Pension PlanPO Box 9460
Victoria BC V8W 9V8Web worksafe.pensionsbc.ca

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

Fax 250-953-0430

Email BPB@pensionsbc.ca**Retired member or beneficiary information**

LAST NAME

FIRST NAME

HOME PHONE *(include ten digits)*STREET ADDRESS *(must be completed)*

CITY OR TOWN

STATE

ZIP CODE

MAILING ADDRESS *(if different than above)*

CITY OR TOWN

STATE / PROVINCE

ZIP / POSTAL CODE

Financial institution informationTYPE OF ACCOUNT – *please check (✓) one:* ☐ Chequing—Attach a VOID cheque ☐ Savings

TRANSIT / ABA NO.

ACCOUNT NO.

FINANCIAL INSTITUTION PHONE NO.
(include ten digits)

ACCOUNT HOLDER(S) NAME(S)

FINANCIAL INSTITUTION NAME AND ADDRESS *(must be completed)*
(include street, city or town, state and zip code)

(STAMP MAY BE USED)

FINANCIAL INSTITUTION OFFICIAL SIGNATURE

DATE SIGNED

YYYY-MM-DD

I understand that my monthly pension payments will be converted in U.S. dollars and deposited in the account that I have provided. I agree to accept the exchange rate applied and I understand it may vary from month to month. I agree to the Pension Corporation sharing my personal information with a bank, trust company or credit union located in the United States to permit the electronic payment of my pension. I acknowledge and agree that the personal information requested on this form may be collected, used, disclosed or stored outside of Canada.

RETIRED MEMBER OR BENEFICIARY SIGNATURE *(must be completed)*

DATE SIGNED

YYYY-MM-DD

Freedom of Information and Protection of Privacy Act—The personal information requested on this form is collected under the authority of the *Workers Compensation Act* and will be used to administer a plan member's pension and other non-pension benefits. The *Freedom of Information and Protection of Privacy Act* protects the personal information collected from unauthorized use and disclosure. If you have any questions about the collection, use or disclosure of this information, contact the privacy officer at PO Box 9460, Victoria BC V8W 9V8 or by telephone at 250-387-1002.

If you wish to keep a copy for your records, please photocopy**STAFF USE ONLY**

DATE CODED

YYYY-MM-DD

INITIALS