



SHEPP

SASKATCHEWAN HEALTHCARE
EMPLOYEES' PENSION PLAN

201 - 4581 Parliament Ave.
Regina, SK S4W 0G3
Phone 306.751.8300
Toll-Free 1.866.394.4440
Fax 306.751.8301
E-mail sheppinfo@shepp.ca
Website www.shepp.ca

Authorisation for Third Party Access to Private Information

FOR OFFICE USE ONLY: 003

CASE ID: _____

1 Personal Information

Member Information

Name _____ First Name _____ Middle Name _____ Last Name _____ Member ID # _____
SIN _____ Date of Birth _____ (dd/mm/yyyy)

2 Third Party Information

It is SHEPP's policy not to disclose a member's personal information to a third party unless the member has provided SHEPP with written authorisation to do so. This form authorises SHEPP to share the member's personal information (including, but not limited to: contribution and earnings records; pension eligibility; benefit amounts; and beneficiary designations) with the third party identified below.

NOTE: Unlike a Power of Attorney, individuals provided authority via this written authorisation may not act or make decisions on behalf of a member or pensioner; they are only authorised to access the member's information from SHEPP.

First Name _____ Initial _____ Last Name _____ Relationship _____
Company (if applicable) _____ Address _____
City _____ Province _____ Postal Code _____ Phone _____ (###)###-####

Note: To authorise more than one third party, please submit a separate authorisation form for each of them.

3 Declaration and Authorisation

Member Declaration

I authorise the Saskatchewan Healthcare Employees' Pension Plan (SHEPP), and its representatives, to provide any and all information pertaining to my SHEPP pension and discuss any relevant matter pertaining to me with the third party identified above via telephone, and/or other mediums of communications. I understand that it is my responsibility to notify SHEPP of any changes regarding authorisation, and that SHEPP is not responsible for the effect of this authorisation.

This authorisation is effective upon receipt by SHEPP and is to remain in effect:

for an ongoing period, until I provide written direction to revoke the authority granted by this document

for the time period:

from _____ (dd/mm/yyyy) to _____ (dd/mm/yyyy)

I certify that the information on this form is correct to the best of my knowledge.

Member Authorisation

Member Signature _____

Date _____ (dd/mm/yyyy)

Note: The signing witness must be someone other than the third party being authorised by this form.

Witness Signature _____

Witness Name (please print) _____

Date _____ (dd/mm/yyyy)