Authorization for Third Party Access to Private Information

SHEPP
People. Pensions. Results.

1 Personal Information

FORM ID: 003 CASE ID: _____

Member Information

First Name _____ Middle _____ Last Name _____

SIN _____ Date of Birth (dd/mm/yyyy) _____ Member ID# _____

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 authorization to do so. This form authorizes 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 Power of Attorney, individuals provided authority via this written authorization may not act or make decisions on behalf of a member or pensioner; they are only authorized 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 authorize more than one third party, please submit a separate authorization form for each of them.

3 Declaration and Authorization

Member Declaration

I authorize 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 authorization, and that SHEPP is not responsible for the effect of this authorization.

This authorization 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 Authorization

_____ _____

Member Signature Date (dd/mm/yyyy)

_____ _____

Witness Signature Date (dd/mm/yyyy)

_____

Witness Name (please print)

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

Instructions

✓ **Submit this form to SHEPP**

✓ **Keep a copy for your files**

SHEPP recognizes and respects the importance of your privacy. Personal information collected is used for the purpose of administering your benefits under the Plan.

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