McMaster University

POST RETIREMENT BENEFITS CO-PAY FORM

A GENERAL EMPLOYEE INFORMATION

First Name & Initial(s)	Surname	
Employee ID	Policy Number **025018**	Benefit Group: MUFA ☐ Clinical Faculty ☐
Former Department		Pension Election: Monthly ☐ Commuted Value ☐ N/A ☐

CO-PAYMENT OPTIONS

INITIAL ONLY THE SECTION (B, C, D OR E) WHICH APPLIES TO YOU.

B RETIREE ELECTED MONTHLY PENSION

_____ I authorize the University to deduct my contribution to the cost of post-retirement benefits directly from my monthly pension payment in an amount as updated by the University annually.

C RETIREE ELECTED COMMUTED VALUE

_____ I understand that I am required to provide 12 postdated cheques, each year dated the first of each month, to the University to account for my contribution to the cost of post-retirement benefits, in amount(s) as communicated to me by the University. Benefit rates are subject to change effective May 1 each year and increased payments may be required. My participation in the post-retirement benefits co-pay program will cease, and I cannot re-enroll in the event I have not provided sufficient funds over any two month period.

D CLINICAL FACULTY WITHOUT PENSION (FULL TIME APPOINTMENT WITH 10 YEARS OF CONTINUOUS SERVICE)

_____ I understand that I am required to provide 12 postdated cheques, each year dated the first of each month, to the University to account for my contribution to the cost of post-retirement benefits, in amount(s) as communicated to me by the University. Benefit rates are subject to change effective May 1 each year and increased payments may be required. My participation in the post-retirement benefits co-pay program will cease, and I cannot re-enroll in the event I have not provided sufficient funds over any two month period.

E DECLINE COVERAGE

_____ I do not wish to participate in the Post-Retirement Benefit Co-Pay program. I understand that declining this coverage I am permanently opting-out of both health and dental coverage in retirement and cannot re-enroll in post-retirement benefits at a later date.

NOTICE OF COLLECTION OF PERSONAL INFORMATION

The information gathered on this form is collected under the authority of *The McMaster University Act, 1976*. The information is used only academic, administrative, employment-related, financial and/or statistical purposes of the University including, but not limited to, admissions; registration and maintaining records; awards and scholarships; convocation; provision of student services, including access to information systems; alumni relations; and disclosure to or on behalf of the applicable McMaster student government. This information is protected and is being collected pursuant to section 39(2) and section 42 of the *Freedom of Information and Protection of Privacy Act* of Ontario (RSO 1990). **If you have any questions about the collection and use of this information please contact your Human Resources Services Office** or the Privacy Office (University Secretariat), Gilmour Hall, Room 210, McMaster University.

F FOR HR USE ONLY

Completed By:	Updated in HRIS and Sun Life Systems Completion Date (DD/MM/YYYY)	Cheques Received ☐
Comments:		

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date