



## Musicians' Pension Fund of Canada

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www.mpfcanada.ca

Spouse is a person to whom you are married or with whom you are living in a common-law relationship for a specific period of time,.

**NOTE:** The definition of spouse varies by province. If you have an eligible spouse, pension legislation or the terms of this Plan or both may provide that your spouse has the right to any benefits payable on your death unless that right is waived. If you do not have an eligible spouse, please complete the following **Beneficiary information**. If you do not wish to designate a beneficiary please indicate **Estate**.

This Beneficiary Appointment Section must be signed and dated. Your signature must be witnessed by an adult other than your spouse or beneficiary.

# Member Information / Change of Beneficiary

If you change your address, please notify the Fund office immediately. Please type or print all information.

Last Name of Member (Legal Name)		First Name	Initial
Professional Name		Social Insurance Number	
Address			(Box No. / Apt. No.)
City	Province	Postal Code	
Date of Birth (mm/dd/yyyy)	Telephone	email	
<b>Sex:</b>	Male Female	<b>Marital Status:</b>	Single Separated Widowed Married Divorced Common-Law

## SPOUSE INFORMATION

Spouse's Last Name (if different)	Spouse's First Name	Initial
Date of marriage or commencement of co-habitation if currently living with spouse, (mm/dd/yyyy)		
Spouse's Date of Birth (mm/dd/yyyy)	Spouse's Social Insurance Number	

## BENEFICIARY INFORMATION

Beneficiary's Last Name	Beneficiary's First Name	Initial
Relationship of Beneficiary	<b>Sex:</b> Male      Female	
Address of Beneficiary (if different from yours)	(Box No. / Apt. No.)	
City	Province	Postal Code
Beneficiary's Date of Birth (mm/dd/yyyy)	Telephone	Social Insurance Number

## MEMBER DECLARATION

I hereby appoint as my beneficiary for Pension and other benefits resulting from my death for which I qualify under the named Plan the beneficiary named herein, reserving to myself the right to change or revoke such appointment notwithstanding acceptance thereof and subject to any legal restrictions, by written notice to the Administrator of the Plan.

I hereby authorize the use of the information contained on this form including my social insurance number, by the Board of Trustees, its agents and employees and by my Employer for the administration of my benefits.

Signature of Member	Date
Signature of Witness	Date