CONTRIBUTORY PROFESSIONAL RETIREMENT SAVINGS PLAN APPLICATION

BRITISH COLUMBIA MEDICAL ASSOCIATION

PLEASE TYPE OR PRINT

PERSONAL INFORMATION

NAME	MSP#	BIRTHDATE (YYYY)
ADDRESS		
CITY	POSTAL CODE	PHONE #

RETIREMENT SAVINGS PLAN INFORMATION

1. TOTAL AMOUNT YOU ARE CLAIMING FROM THE CPRSP THIS YEAR	$
2. TOTAL AMOUNT YOU HAVE CONTRIBUTED TO DATE FOR THE CURRENT TAXATION YEAR (this amount must not include any previous BCMA deposit)	$

FOR PROOF OF YOUR CONTRIBUTION, PLEASE COMPLETE ONE OF THE FOLLOWING:

☐ A) I MADE MY CONTRIBUTION OF $ _____ TO MY MD MANAGEMENT/MD PRIVATE INVESTMENT ACCOUNT # _____
I AUTHORIZE MD MANAGEMENT/MD PRIVATE INVESTMENT TO PROVIDE PROOF OF THIS TO THE BCMA.

☐ B) MY RRSP IS WITH ANOTHER FINANCIAL INSTITUTION
COPY OF CONTRIBUTION RECEIPT AND/OR STATEMENT OF CONTRIBUTION ATTACHED.

NON MEMBERS: If you are not a member of the BCMA in the year the entitlement is allotted, an administration fee of $300 plus GST or 50% of your entitlement plus GST, whichever is less, is payable to the BCMA for each such year being claimed.

☐ Enclosed is my cheque for Administration Fees OR ☐ Deduct this fee from my benefit amount

FINANCIAL INSTITUTION

I hereby authorize the British Columbia Medical Association to remit my entitlement from the Contributory Professional Retirement Savings Plan (CPRSP) to the financial institution shown below. If you are applying for an IPP payment, the BCMA will make payment directly to your corporation.

PAYABLE TO (Name of Financial Institution or Corporation for IPP holdings):

_____

ADDRESS OF FINANCIAL INSTITUTION:

_____

_____

_____

POSTAL CODE

RSP ACCOUNT #: _____

ACCOUNT TYPE:

☐ PERSONAL RSP

☐ SPOUSAL RSP

NAME: _____ BIRTHDATE (mm/dd/yyyy): _____

☐ INDIVIDUAL PENSION PLAN (IPP) Plan Reg. #: _____

CONDITION OF ACCEPTANCE

I hereby certify that the information provided on and with this application is truthful and accurate. I agree that any funds I have received or will receive in the future from the CPRSP, my matching contributions, and any accrued interest will not be withdrawn from a Registered Savings Plan until my retirement from active medical practice in British Columbia. I have read and understand the plan rules as outlined on the back of this application. I authorize the use of the information contained in this application for the administration of the Membership/Benefit programs.

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

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