

Buyback Quote Information Form



July 2011

Print clearly using black ink.

- Please ensure all required information is submitted in order for HOOPP to process your request.
- If you have former pension plan information see section 4 on the back of this form.

1. Member Information *(Member to fill out this section, ensure that it is signed.)*

Name: Miss Mrs. Ms. _____
 Mr. Sister Dr. first name last name middle initial(s)

Social insurance number (SIN): Tel: _____

E-mail: _____ Signature: _____ Date: |_____| |_____| |_____|
month day year

Proof of age attached

Name of employer you wish to purchase the eligible period _____

Please indicate one of the following:

- Former HOOPP vested/non-vested contributions made in HOOPP – complete section 2 only
- Former HOOPP employment – complete section 2 & 3 only Waiting period Leave of absence
- PBA (former pension plan) – complete section 2 & 4 only

2. Annualized Earnings *(To be filled out by your current employer.)*

Member's current year annualized earnings: \$ _____ \$ _____
current year previous year

Current employer's contact name: _____ Signature: _____ Tel: _____

3. Service History *(To be filled out by employer(s) where a period of time could apply – if data is no longer on record, please estimate where necessary.) Please provide the information for each full calendar year.*

Date <i>(mm/dd/yy to mm/dd/yy)</i>	Annualized Earnings <i>(post-89 service only)</i>	Service <i>(hours worked, days worked)</i>	Employment status <i>(if PT indicate FT hours for year i.e. 1950/1820)</i>	Was the member on a (non-contributory) leave?
			<input type="checkbox"/> FT <input type="checkbox"/> PT _____	
			<input type="checkbox"/> FT <input type="checkbox"/> PT _____	
			<input type="checkbox"/> FT <input type="checkbox"/> PT _____	
			<input type="checkbox"/> FT <input type="checkbox"/> PT _____	
			<input type="checkbox"/> FT <input type="checkbox"/> PT _____	

If the member was part time, provide hours worked for the 10 weeks preceding the leave _____

Employer Contact Information *** Use another form for additional employers

Employer name: _____ Code: _____

Contact name: _____ Tel: _____

Signature: _____

E-mail: _____ Date: |_____| |_____| |_____|
month day year

Healthcare of Ontario Pension Plan

1 Toronto St., Suite 1400 Tel: 416-646-6445
 Toronto, ON Toll-free: 1-877-43HOOPP(46677)
 M5C 3B2 Fax: 416-369-0225
 Website: hoopp.com E-mail: clientservices@hoopp.com

- Send this form to HOOPP
- Keep a copy for your files

4. Former Pension Plan Information (If former pension plan does not have the required information on record please forward to the employer.)

Name of former pension plan/employer: _____

Date member *joined* former pension plan:

Date member *left* former pension plan:

_____|_____|_____|
month day year

_____|_____|_____|
month day year

Estimated contributions with interest available for transfer: \$ _____

Estimated commuted value available for transfer: \$ _____

Total accrued pensionable service: (weeks/years) _____

Dates of any non-contributory leaves: _____

Type of plan: DB (defined benefit) DC (defined contribution)

Plan Registration #: _____

Are the funds still in the plan? Yes No

Please provide the information for **each** full calendar year.

Date (mm/dd/yy to mm/dd/yy)	Annualized Earnings (post-89 service only)	Service (hours worked, days worked)	Employment Status (if PT indicate FT hours for year i.e. 1950/1820)	Pension Adjustment (post-89 service only – required for transfers from former pension plan only)	Was the member on a (non-contributory) leave?
			<input type="checkbox"/> FT <input type="checkbox"/> PT _____		
			<input type="checkbox"/> FT <input type="checkbox"/> PT _____		
			<input type="checkbox"/> FT <input type="checkbox"/> PT _____		
			<input type="checkbox"/> FT <input type="checkbox"/> PT _____		
			<input type="checkbox"/> FT <input type="checkbox"/> PT _____		
			<input type="checkbox"/> FT <input type="checkbox"/> PT _____		
			<input type="checkbox"/> FT <input type="checkbox"/> PT _____		

Employer/Pension Plan Contact Information

Plan/ER: _____

Contact name: _____

Signature: _____

Tel: _____

E-mail: _____

Date: _____

Employer/Pension Plan Contact Information

Plan/ER: _____

Contact name: _____

Signature: _____

Tel: _____

E-mail: _____

Date: _____

*** Use another form for additional plans/employers