



PENSION PLAN ENROLMENT - PART TIME EMPLOYEES (PUBLIC SAFETY OCCUPATIONS ONLY)

PART I (TO BE COMPLETED BY THE EMPLOYEE)

Name of Pension Plan: Halifax Regional Municipality Pension Plan

Employee Location/Division: _____

Employee Last Name _____ Employee First Name _____ Employee Number _____

Date of Birth: _____
Year Month Day Employee Social Insurance Number Gender

ELECTION TO PARTICIPATE

I understand that eligibility for membership in the Plan is optional and is not mandatory for part-time employees. Should I choose not to participate at this time, I may join on the 1st day of January or July of any year, provided I meet the minimum earnings and service criteria. I also understand that once I join the Plan, I will not be able to end or suspend my participation.

- I elect to participate in the pension plan at this time.
- I elect NOT to participate in the pension plan at this time.

VOLUNTARY CONTRIBUTIONS ELECTIONS

I would like to make contributions on overtime and other non-regular taxable earnings.
 Yes Employee contributes 6.3% to a DC Account, the employer will match the employee contributions
 No

I am a member of the Halifax Regional Police Association Union and I would like to make contributions on extra duty earnings.
 Yes Employee contributes 12.6% to a DC Account, the employer DOES NOT contribute
 No

PAST ELIGIBLE SERVICE

For questions regarding eligibility to purchase or transfer pensionable service from a former employer or past service with your current employer, please contact the HRM Pension Plan Office (see contact information below). Note that some options have time limits, so you should investigate your options as soon as possible following your enrolment in the pension plan.

CONSENT AND MEMBER SIGNATURE

By way of my signature, I consent to the use of the data shown on this form or collected from time to time that is required for the administration of the Plan. This would include daily administration, benefit calculations, annual statements, annual reporting, plan valuations and benefit costings.

I hereby acknowledge that I have been informed of my membership in the above-mentioned pension plan and, if applicable, authorize my employer to make the required payroll deductions, as specified in the pension plan or, as the case may be, in the collective bargaining agreement, starting from my Date of Membership.

_____ Date _____ Member signature

PART II (TO BE COMPLETED BY THE EMPLOYER REPRESENTATIVE)

Date of Employment: _____ Date of Membership: _____
Year Month Day Year Month Day

_____ Date _____ Employer Representative - Print Name _____ Employer Representative signature

Please have this form completed by the Employer Representative, set up plan options and record DC options (if applicable). Once fully completed, the Employer Representative should mail this form, along with the completed *Beneficiary and Spouse Designation Form*, to the HRM Pension Plan Office at the address below. Call 1-902-490-6213 or toll-free at 1-888-490-6213 with any questions.
HRM Pension Plan Office, 1108-1809 Barrington Street Halifax, Nova Scotia B3J 3K8

