



Potential Enrollment in the Nova Scotia Health Employees' Pension Plan (NSHEPP)

Participation in the NSHEPP is based on specific criteria. Answer the following questions to ensure that your participation in the pension plan occurs at the appropriate time.

Please answer all of the following questions.

1. You are **required** to enroll in the NSHEPP if you continue to be employed with another employer where you are contributing to the NSHEPP. Any further change in status with another employer should be reported to Benefits at (902) 473 5757 Option 3, Option 1.

I am contributing to the NSHEPP at another organization.

NO YES NAME OF EMPLOYER _____

2. You have the **option** of immediately rejoining the NSHEPP **if you terminated employment within the last 6 months with another employer where you were a member of the NSHEPP and have not withdrawn any monies from the Plan.** If you immediately rejoin, your prior period of service will combine with the current period of service to determine how much pension you will receive from the NSHEPP and when you can retire.

I have paid into the NSHEPP within the last 6 months and have not withdrawn my monies.

NO YES

If you have answered "yes" to question #2 you have the option of joining the Plan. Please indicate your decision below:

I wish to immediately participate in the NSHEPP. YES NO

If you choose to join the plan, please supply the name of any NSHEPP participating employer you were employed with in the last 6 months. _____

Note: If you are not eligible for the reasons noted above, once you have completed 24 consecutive months of continuous service with either worked 700 hours or your earnings equal 35% of the Years Maximum Pensionable Earnings (YMPE) under the Canada Pension Plan in each of the preceding two calendar years, you will be eligible and have the option to participate in the NSHEPP.

You have been provided with a link to an electronic version of the NSHEPP Employee Information booklet. If you would like a hard copy, you can either print the electronic version or request one by calling Benefits at 902 473 5757, Option 3, Option 1.

I understand the information that has been presented to me and confirm my answers to be factual.

Signature: _____ Print: _____

SIN: _____ Date: _____

Witness: _____ Date: _____

Declaration: I authorize the use of my Social Insurance Number for group identification purposes. (rev Nov/18)