

**Note:** In order to keep your personal information confidential, CARRA cannot send your pension estimate by fax.

**Identification of member**

Please use block letters to complete this form.

|  |  |  |   |           |
|--|--|--|---|-----------|
| Last name  |  | Social insurance number  |   |           |
| First name   |  | Sex<br>M <input type="checkbox"/> F <input type="checkbox"/>   | Date of birth<br>year      month      day |           |
| Address (number, street, apartment, P.O. Box, rural route)   |  |  |   |           |
| City or town   |  | Province   | Postal code                               |           |
| Language of correspondence<br>English <input type="checkbox"/> French <input type="checkbox"/>                                 |  | Telephone (home)<br>(area code)  | Telephone (work)<br>(area code)           | Extension |
| Estimated date of retirement<br>year      month      day   |  | Pension plan   |   |           |
| Do you currently receive salary insurance benefits for disability?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  | If so, do your work conditions provide that your employment relationship will end at the end of the 2nd year of exemption from contribution? (this information may be obtained from your employer)<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   |           |
| Member's signature   |  |  | Date<br>year      month      day          |           |

**Identification of the person authorized to receive the documents requested**

|  |  |  |                                  |  |
|--|--|--|----------------------------------|--|
| I hereby authorize CARRA to send a copy of my pension estimate, my statement of contributions and my explanatory letter, as the case may be, to the person identified below. |  |  |                                  |  |
| Member's signature   |  |  | Date<br>year      month      day |  |

|  |  |                                 |                                 |  |
|--|--|---------------------------------|---------------------------------|--|
| Authorized person's last name                              |  | First name                      |                                 | Sex<br>M <input type="checkbox"/> F <input type="checkbox"/> |
| Name of agency (if applicable)                             |  |                                 |                                 |  |
| Address (number, street, apartment, P.O. Box, rural route) |  | Telephone (home)<br>(area code) | Telephone (work)<br>(area code) | Extension  |
| City or town   |  | Province                        | Postal code                     |  |

In this form, the masculine is taken to include the feminine

Failure to provide the information requested on this form can prevent the processing of your application. Under the *Act respecting Access to documents held by public bodies and the Protection of personal information* (R.S.Q., c. A-2.1), the information will be disclosed only to authorized agents. The Act allows you to examine your personal information and ask for corrections.

**Please send this form by fax at (418) 644-8659. This number is reserved for this purpose.**

Client services:

(418) 643-4881 (Québec City area)  
1 800 463-5533 (elsewhere in Québec)

Commission administrative des régimes  
de retraite et d'assurances  
475, rue Saint-Amable  
Québec (Québec) G1R 5X3