

REGISTERED EDUCATION SAVINGS PLAN APPLICATION
Construction Plan - Active Members Only

 Send to: LiUNAcare Local 183 | 2100 – 200 Labourers Way | Vaughan, ON L4H 5H9
 P: 416.240.7487 | F: 416.240.7488 | w: www.liunacare183.com | e: info@liunacare183.com

A Member Information (Please Print)

Last Name:	First Name:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		Birth Date (yyyy/mm/dd):
Town/City:	Province:	Postal Code:
Country:		Telephone #:
Union ID <i>or</i> Social Insurance Number (SIN):		Cell #:
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Common-Law <input type="checkbox"/> Single <input type="checkbox"/> Seperated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow		

B Child Information (Please Print)

First Name:	Last Name:	Birth Date (yyyy/mm/dd):		
On behalf of the above Union Member, we are requesting the lifetime RESP benefit contribution by the LiUNA Local 183 Members' Group Legal and Paid Leave Trust Fund to be payable as per below for every child or grandchild born: <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="padding: 0 10px;">on or after January 1, 2017 - \$500.00</td> <td style="padding: 0 10px;">on or between January 1, 2000 to December 31, 2016 - \$100.00</td> </tr> </table>			on or after January 1, 2017 - \$500.00	on or between January 1, 2000 to December 31, 2016 - \$100.00
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C Payment Information (Please Print)

Please Make Cheque Payable to RESP Institution:

RESP Account #:

Address:	City:
Province:	Postal Code:
Phone No.:	

For eligible active members requesting the RESP contribution for a grandchild, an affidavit must be completed and signed by the Local 183 Group Legal Department and attached to this form. There are absolutely no exceptions. The RESP benefit is for eligible active members in the Construction Plan only.

I, certify that the above information is correct and understand that any incorrect or misleading information may result in the denial of being offered the Registered Education Savings Plan benefit contribution.

Member Name: _____
 (Please Print)

Member Signature: _____ Date: MM / DD / YYYY

To be Completed by Institution (Bank)

Authorized Institution Signator: _____

Name: _____
 (Please Print)

Title: _____ Date: MM / DD / YYYY

 INSTITUTION
 STAMP