HOOPP
Healthcare of Ontario
Pension Plan

# Letter of Authorization

Complete this form to authorize the Healthcare of Ontario Pension Plan (HOOPP) and its representatives to disclose your personal information and to discuss any matters related to your HOOPP benefits to a third party. You can cancel this authorization at any time by contacting HOOPP Client Services.

**Important!** A Power of Attorney is required for the person listed below to **act or make decisions** on your behalf regarding your HOOPP benefits.

Please print clearly and review the form to ensure the information you provide is complete and accurate.

## Section 1: Member Information

First Name

Last Name

SIN

Telephone Number

Email

## Section 2: Third Party Information

First Name

Last Name

Address

City

Province

Postal Code

Company / Organization (if applicable)

Expiry Date of Authorization (optional)

## Section 3: Member Authorization

I authorize HOOPP and its representatives to disclose my personal information and to discuss any matters relating to my HOOPP benefits to the individual identified in Section 2. I understand that this authorization remains in effect until the expiry date set out above or until I cancel it by contacting HOOPP.

Member Name (please print)

Signature of Member

Date (MM / DD / YYYY)

**Your privacy is important to us!** At HOOPP, safeguarding the privacy of our members is a priority. We collect, use and disclose our members' personal information only for the purpose of administering the Plan; this refers primarily to administering pension benefits and paying pensions after retirement. For more information on HOOPP's privacy policies and practices, please visit **hoopp.com**.

**Healthcare of Ontario Pension Plan**

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