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Retraite Québec

Declaration to Ensure the Non–Interruption of Benefits

Québec Pension Plan and public-sector pension plans

The form must be completed and signed by the beneficiary if he or she is able to manage his or her affairs.

1. Information on the identity of the beneficiary

Client number of the beneficiary	Client number of the contributor
C L 0 5 4 3 4 6 9 3 1	C L 0 5 4 3 4 6 9 3 1

Sex	Family name	Given name
☐ F ☒ M	KRATZ	DETLEF

Family name at birth, if different	Date of birth (year month day)
	1 9 4 6 0 5 1 4

Full address (number, street, apartment or Post Office Box) City, Province, Country and Postal code

AM EICHENQUAST 44
12353 BERLIN
ALLEMAGNE

Telephone	Language of correspondence
Home (area code) Other (area code)	☐ French ☒ English

Corrected address, if applicable

Address (number, street, apartment or Post Office Box)

City	Province	Country	Postal code

I declare that the information provided on this questionnaire is complete and accurate.

Signature of the beneficiary _____ Date (year month day) _____

If the beneficiary is unable to sign the declaration form, please give the reason and complete Section 2:

_____

_____

If the person is deceased, please give the date of his or her death: (year month day) _____

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