



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 C L 0 5 4 3 4 6 9 3 1	Client number of the contributor C L 0 5 4 3 4 6 9 3 1
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Sex <input type="checkbox"/> F <input checked="" type="checkbox"/> M	Family name KRATZ	Given name DETLEF	Date of birth year month day 1 9 4 6 0 5 1 4
Family name at birth, if different			

Full address (number, street, apartment or Post Office Box) City, Province, Country and Postal code
 AM EICHENQUAST 44
 12353 BERLIN
 ALLEMAGNE

Telephone Home area code 030 660 06621 Other area code	Language of correspondence <input type="checkbox"/> French <input checked="" type="checkbox"/> English
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Corrected address, if applicable

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

City	Province	Country	Postal code
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I declare that the information provided on this questionnaire is complete and accurate.

Signature of the beneficiary *Detlef Kratz* Date 20 23 10 24

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