

# APPLICATION FOR WITHDRAWAL OF EQUITY

RETAIL Prairie Sky Co-operative Association Ltd

DATE : \_\_\_\_\_

MEMBER NAME \_\_\_\_\_

MEMBER NUMBER \_\_\_\_\_

ADDRESS \_\_\_\_\_

MEMBER TEL # : \_\_\_\_\_

\_\_\_\_\_  
CITY PROVINCE POSTAL CODE

EMAIL : \_\_\_\_\_

## REASON FOR WITHDRAWAL – CHECK OFF A BOX AND COMPLETE DETAILS

- ESTATE – ADMINISTRATORS ARE: NAME/S**  
STATEMENT OF DEATH NEEDED

Tel# \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_  
CITY PROVINCE POSTAL CODE

- MOVED – FROM THIS CO-OPERATIVE TRADING AREA TO:**  
PROOF OF NEW ADDRESS IS NEEDED

ADDRESS \_\_\_\_\_

DATE MOVED: \_\_\_\_\_

\_\_\_\_\_  
CITY PROVINCE POSTAL CODE

PROOF OF NEW ADDRESS SHOWN TO \_\_\_\_\_ (STAFF MEMBER'S FULL NAME & SIGNATURE)

- AGE (AS PER BYLAW):** \_\_\_\_\_ **BIRTH DATE** \_\_\_\_\_

AS PER POLICY MEMBER MUST BE 65 YEARS OF AGE  
WE RETAIN A FEE OF \$ 200.00 TO KEEP THE MEMBERSHIP ACTIVE

\_\_\_\_\_  
YEAR MONTH DAY

PROOF OF AGE SHOWN TO \_\_\_\_\_ (STAFF MEMBER'S FULL NAME & SIGNATURE)

- OTHER (SPECIFY)** \_\_\_\_\_

\_\_\_\_\_  
(MORE INFORMATION/DOCUMENTS MAY BE REQUIRED FOR APPROVAL)

- TRANSFER EQUITY** STATEMENT OF DEATH & THE LAST WILL OR INSTRUCTION FROM A LAW FIRM

TO: NAME \_\_\_\_\_

MEMBER NUMBER \_\_\_\_\_

ADDRESS \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

\_\_\_\_\_  
YEAR MONTH DAY

\_\_\_\_\_  
CITY PROVINCE POSTAL CODE

SIN \_\_\_\_\_

ALL EXECUTORS NAMED AS PER LAST WILL NEED TO SIGN AT APPLICANT BELOW FOR A TRANSFER TO BE APPROVED

PHONE \_\_\_\_\_

IF 'ESTATE' OR 'MOVED' OR 'OTHER' WAS SELECTED - APPLICANT TO CHECK **ONE** OF THE FOLLOWING

- I REQUEST PAYMENT IN FULL, AND BY SO DOING, AM AWARE THAT I AM NOT ELIGIBLE FOR ANY PATRONAGE REFUNDS WHICH MAY BE ALLOCATED, AFTER PAYMENT IS MADE.** (A CLOSED MEMBERSHIP NUMBER CANNOT BE REINSTATED)

- REPAY ONLY AFTER ALLOCATION FOR THE CURRENT YEAR HAS BEEN DECLARED AND PROCESSED.**  
(ALLOCATION REPAYMENT IS JUNE OF EACH YEAR)

The Co-op respects your privacy. The personal information in this form will be used to communicate with you and to administer the Equity and Cash Back Program. The Co-op requires your Social Insurance Number (SIN) because the law requires us to report patronage allocations for income tax purposes. Your date of birth is used to administer the overage policy with respect to the Equity and Cash Back Program.

I understand that by signing this application form, I am consenting to the collection of my personal information and to its use for the stated purposes.

**APPLICANT'S SIGNATURE** \_\_\_\_\_

Title of applicant(s) \_\_\_\_\_

(Business memberships)

MAILING ADDRESS \_\_\_\_\_

\_\_\_\_\_  
CITY PROVINCE POSTAL CODE

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**FOR OFFICE USE ONLY**

DATE APPROVED BY BOARD

AMOUNT OF EQUITY \$ \_\_\_\_\_

PAYMENT DUE PER POLICY \_\_\_\_\_

DEDUCT - ACCOUNTS RECEIVABLE ( IF ANY ) \_\_\_\_\_

- MEMBERSHIP FEE OF \$ \_\_\_\_\_  
TO BE RETAINED

AMOUNT OF PAYMENT \$ \_\_\_\_\_

CHEQUE NUMBER \_\_\_\_\_

\_\_\_\_\_  
DD / MM / YYYY

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