

# APPLICATION FOR WITHDRAWAL OF EQUITY

REV '22

RETAIL Prairie Sky Co-op

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

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

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

ADDRESS \_\_\_\_\_

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

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

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

## REASON FOR WITHDRAWAL – CHECK ONE AND COMPLETE DETAILS

**ESTATE – ADMINISTRATORS ARE: NAME/S** \_\_\_\_\_ **Tel#** \_\_\_\_\_  
STATEMENT OF DEATH NEEDED  
**ADDRESS** \_\_\_\_\_  
CITY \_\_\_\_\_ PROVINCE \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

**MOVED – FROM THIS CO-OPERATIVE TRADING AREA TO:**  
6 MONTH INACTIVE PERIOD REQUIRED  
**ADDRESS** \_\_\_\_\_  
Date moved: \_\_\_\_\_  
CITY \_\_\_\_\_ PROVINCE \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

**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  
PROOF OF AGE SHOWN TO \_\_\_\_\_ (STAFF MEMBER'S SIGNATURE) PLEASE ATTACH ID SHOWING D.O.B. IF NOT IN PERSON AT ADMIN

**OTHER (SPECIFY)** \_\_\_\_\_  
(more information may be required)

**TRANSFER EQUITY** STATEMENT OF DEATH & THE LAST WILL 1ST PAGE (EXECUTOR NAMED) AND LAST PAGE (WITH SIGNATURE) OR INSTRUCTION FROM A LAW FIRM

**TO: NAME** \_\_\_\_\_ **MEMBER NUMBER** \_\_\_\_\_  
**ADDRESS** \_\_\_\_\_ **BIRTH DATE** \_\_\_\_\_  
CITY \_\_\_\_\_ PROVINCE \_\_\_\_\_ POSTAL CODE \_\_\_\_\_ YEAR MONTH DAY  
**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.**
- 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** \_\_\_\_\_

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

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

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 \_\_\_\_\_