Clear Form

Locked-In Plans

Federal (PBSA) Jurisdiction

APPLICATION TO WITHDRAW MONEY FROM A LIRA OR LIF BECAUSE OF CONSIDERABLY SHORTENED LIFE EXPECTANCY.

1. Applicant's Information:

NAME: _____

ADDRESS: _____

SIN: _____ CONTRACT NO: _____

OPTIONS:
- ☐ FULL WITHDRAWAL
- ☐ PARTIAL WITHDRAWAL
- ☐ TRANSFER TO RRSP/RRIF

* Attach required application

Applicant's Signature: _____ Date: _____

2. Spousal Consent: Complete A or B

A. I, _____, owner of the Locked-In RRSP or LIF as noted above, declare that I have no "spouse or common-law partner" as defined in the Act and Regulations.

Signature: _____ Date: _____

OR

B. I, _____, am the spouse/common law partner of the applicant/owner of the above-noted Locked-In RRSP or LIF. I understand that if my spouse/common-law partner elects to withdraw the designated amount or total amount permitted in accordance with the PBSA Federal Jurisdiction "withdrawal of funds due to shortened life expectancy", the level of income or benefit available to me in later years will be significantly reduced or depleted.

Spouse/Common Law Partner's Signature: _____

Date: _____

Witness: _____ Date: _____

Statement of a Physician for a Withdrawal Based on Shortened Life Expectancy

If the owner of the LIRA or LIF is applying to withdraw money from the LIRA or LIF because the owner has a mental or physical disability that is likely to shorten considerably the owner's life expectancy, the owner's application must include a statement signed by a physician licensed to practice medicine in a jurisdiction in Canada. It must state that, in the physician's opinion, the owner has such a mental or physical disability. This requirement will be satisfied if a physician completes the Physician's Statement set out below.

The owner of the LIRA or LIF cannot complete the Physician's Statement.

If you are a physician licensed to practice medicine in a jurisdiction in Canada, you may complete the Physician's Statement below in order to provide your opinion for the purposes of the owner's application. If you wish to complete the Physician's Statement below, please fill in the owner's name at the top of the Statement and read the Statement. If you are satisfied that the Statement correctly describes the owner's situation, then please sign, date and fill in the information at the bottom of the Statement.

Physician's Statement

I am a physician licensed to practice medicine in a jurisdiction in Canada. In my opinion,

_____

has a mental or physical disability that is likely to shorten considerably his or her life expectancy.

Physician's name (print)	Physician's signature	Date (year/month/day)

Physician's address (street number and name)	Suite No.

City	Province	Postal Code