SOUTH COUNTRY CO-OP LIMITED
969 - 16TH ST. SW
MEDICINE HAT AB T1A 4X5

APPLICATION FOR WITHDRAWAL OF EQUITY

DATE: _____

MEMBER NAME: _____ MEMBER NUMBER: _____

ADDRESS: _____

_____
CITY PROVINCE POSTALCODE

REASON FOR WITHDRAWAL (CHECK ONE AND COMPLETE DETAILS)

☐ **ESTATE -** ADMINISTRATORS ARE: NAME: _____

ADDRESS: _____ CITY: _____

PROVINCE: _____ POSTAL CODE: _____

☐ **MOVED** FROM THIS COOPERATIVE TRADING AREA TO:

ADDRESS: _____ CITY: _____

PROVINCE: _____ POSTAL CODE: _____

☐ **AGE** (AS PER BYLAW): _____ BIRTHDATE: _____

PROOF OF AGE SHOWN TO (PRINT & INITIAL): _____

☐ **OTHER** (SPECIFY): _____

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I REQUEST PAYMENT IN FULL, AND BY DOING SO 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

TRANSFER EQUITY TO NAME: _____ MEMBER NUMBER _____

ADDRESS: _____ BIRTHDATE: _____

SIN /BIN: _____

CITY: _____ PROVINCE: _____

POSTAL CODE: _____ PHONE NUMBER: _____

APPLICANTS NAME: _____

APPLICANTS SIGNATURE: _____

PHONE NUMBER: _____

FOR OFFICE USE ONLY

AMOUNT OF EQUITY _____

PAYMENT DUE PER POLICY: _____ CHEQUE #: _____

DEDUCT A/R (IF ANY): _____ PATRONAGE CODE: _____

AMOUNT OF PAYMENT: