CLAIM FORM – BENEFITS

NAME OF FUND

Natal Joint Municipal Pension Fund (Superannuation) ☐

Natal Joint Municipal Pension Fund (Retirement) ☐

KwaZulu-Natal Joint Municipal Provident Fund ☐

Tick as appropriate

PLEASE NOTE : THIS FORM WILL ONLY BE ACCEPTED IF COMPLETED IN ITS ENTIRETY, WITNESSED AND SIGNED

MEMBER DETAILS

Surname and Initials (Dr. /Mr. /Mrs. /Miss.): ……

Identity Number : …….

Pension Number : ……..

Former Employer (Municipality) : ……..

Date of Exit : ……..

Reason for Exit:-

NORMAL RETIREMENT	EARLY RETIREMENT	ILL-HEALTH RETIREMENT	RETRENCHMENT

I hereby instruct the Funds to administer all of the benefits due to me in the following manner :-

1. **LUMP SUM PAYMENT** (If applicable)

1.1. Cheque to be deposited into my personal account details being as following :-
(N.B. DEPOSITS TO A JOINT ACCOUNT OR TO AN ACCOUNT WHICH DOES NOT BELONG TO THE MEMBER/BENEFICIARY ARE NOT PERMISSIBLE):-

1.1.1. **FINANCIAL INSTITUTION**

1.1.1.1	Account Holder's Name	:	…….
1.1.1.2	Name of Bank	:	……..
1.1.1.3	Branch of Bank were account is kept	:	……..
1.1.1.4	Branch Code	:	……..
1.1.1.5	Account Number	:	……..
1.1.1.6	Type – Current, Savings Etc. (Please specify)	:	……..

1.2 In the event that you wish to utilize your lump sum benefit, or part thereof, for the purpose of purchasing a policy from an Insurer, your instructions must be accompanied by written confirmation from the said Insurer in which the policy number is to be quoted.

2. **MONTHLY PENSION PAYMENT** (If applicable)

2.1 Cheque to be deposited into my personal account details being as following :-
(N.B. DEPOSITS TO A JOINT ACCOUNT OR TO AN ACCOUNT WHICH DOES NOT BELONG TO THE MEMBER/BENEFICIARY ARE NOT PERMISSIBLE) :-

2.1.1 **FINANCIAL INSTITUTION**

2.1.1.1	Account Holder's Name	:	…….
2.1.1.2	Name of Bank	:	……..
2.1.1.3	Branch of Bank were account is kept	:	……..
2.1.1.4	Branch Code	:	……..
2.1.1.5	Account Number	:	……..
2.1.1.6	Type – Current, Savings Etc. (Please specify)	:	……..

PERSONAL PARTICULARS OF MEMBER :-

Surname : …….

First Names : …….

Marital Status : .....

POSTAL ADDRESS	**RESIDENTIAL ADDRESS**
…….	……
…….	…….....
…….	…….....
…….	……

Telephone Number : ……... Cell Number: ……....

Tax Reference No: …… Email Address: .....

Are you a Member of Key Health YES NO

Would you like your Medical Aid Contribution Deducted from your Monthly Pension? YES NO

Key Health Membership No: ……

(SUPERANNUATION FUND MEMBERS ONLY)

Should you wish to commute a portion of your pension, please notify the Fund in writing **no later than your last working day.**

3. **OTHER INSTRUCTIONS** (Please specify)

…… ……..
DATE OF SIGNATURE SIGNATURE OF MEMBER

……..
SIGNATURE OF WITNESS
(who has satisfied himself/ herself as to the identity of the member)

NAME AND ADDRESS OF WITNESS: ……..

……..

……..

……..

……..

PLEASE NOTE THAT :

1. Benefits will not be paid unless this form has been correctly completed and lodged at the under mentioned address:-

   POSTAL ADDRESS:
   P.O. Box 33
   Westwood
   3633

   STREET ADDRESS:
   Derby Downs Office Park
   5 Derby Downs
   University Road
   Westville
   3630

2. Facsimile copies of this form are not acceptable.

3. Funds website is: www.njmpf.co.za