VERSO
Defining Excellence
FINANCIAL SERVICES
Bellmont Office Park, Twist Street, Bellville, 7535
P.O. Box 4300, Tyger Valley, 7536
Tel: +27 21 9435300 Fax: +27 21 9174600
FSP Licence No. 14985

FUND ADMINISTRATION FORM
NEW MEMBER APPLICATION

UMBRELLA FUND / FUND NAME _____

PARTICIPATING EMPLOYER _____

MEMBER'S PERSONAL DETAILS

SURNAME _____ FIRST NAMES _____

GENDER: MALE ☐ FEMALE ☐ DATE OF BIRTH _____

IDENTITY NUMBER _____ MARITAL STATUS _____

DATE OF MARRIAGE _____ SPOUSE'S DATE OF BIRTH _____

SPOUSE'S SURNAME AND FIRST NAMES _____ NO. OF CHILDREN _____

PREFERRED LANGUAGE FOR CORRESPONDENCE : ☐ ENGLISH ☐ AFRIKAANS

INCOME TAX REFERENCE NUMBER _____ REVENUE OFFICE OF LAST TAX RETURN _____

MEMBER'S CONTACT DETAILS

POSTAL ADDRESS _____

_____

PHYSICAL ADDRESS _____

_____

HOME TEL NO. (_____)_____ WORK TEL NO. (_____)_____

CELL PHONE NO. _____ FACSIMILE NO. (_____)_____

E-MAIL ADDRESS _____

MEMBER'S BANK DETAILS

NAME OF BANK _____ ACCOUNT HOLDER _____

BRANCH NAME _____ BRANCH CODE _____

TYPE OF ACCOUNT _____ ACCOUNT NUMBER _____

EMPLOYMENT DETAILS

EMPLOYEE NO. _____ EMPLOYER _____

BRANCH _____ COST CENTRE _____

DATE OF JOINING SERVICE _____ DATE OF JOINING FUND _____

ANNUAL PENSIONABLE SALARY _____ OCCUPATION _____

TRANSFER DETAILS

DO YOU WISH TO TRANSFER ANY MONEY FROM YOUR PREVIOUS FUND? ☐ YES ☐ NO

If 'YES', please provide the following information:-

NAME OF PREVIOUS EMPLOYER: _____ EMPLOYEE NO.: _____

NAME OF PREVIOUS FUND: _____ MEMBER NO.: _____

DATE OF TERMINATION FROM PREVIOUS FUND: _____ TYPE OF FUND: _____

HAVE YOU RECEIVED ANY BENEFIT FROM THE PREVIOUS FUND: ☐ YES ☐ NO

IF 'YES', PLEASE PROVIDE DETAILS: _____

_____

DECLARATION

I hereby confirm that the above details are correct and that I will make no claim against the Fund in the event of any loss, damage or claim from the use of this information, or in the event that incorrect information has been supplied by me.

SIGNATURE OF EMPLOYEE _____ DATE _____

SIGNATURE OF EMPLOYER _____ DATE _____

EMPLOYER STAMP

DOCUMENTS

- Only the original form will be accepted, no photocopies or facsimiles.
- No medical certificate is required, however the employee must be in active service on the date of joining the Fund.
- A certified copy of the employee's Identity Document must be attached to this form.
- If married, a certified copy of the Marriage Certificate must be attached to this form.
- The employee must complete a Beneficiary Nomination Form and forward this to the Fund.

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FINANCIAL SERVICES (PTY) LTD

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P.O. Box 4300, Tyger Valley, 7536
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Fax: 021 917 4601
E-mail: info@verso.co.za
Web: www.verso.co.za

FUND ADMINISTRATION FORM
BENEFICIARY NOMINATION

UMBRELLA FUND / FUND NAME _____

PARTICIPATING EMPLOYER _____

MEMBER'S PERSONAL DETAILS

MEMBER NO. _____ EMPLOYEE NO. _____

SURNAME _____ FIRST NAMES _____

DATE OF BIRTH _____ IDENTITY NUMBER _____

POSTAL ADDRESS _____

_____

PHYSICAL ADDRESS _____

_____

HOME TEL NO. (_____)_____ WORK TEL NO. (_____)_____

CELL PHONE NO. _____ FACSIMILE NO. (_____)_____

E-MAIL ADDRESS _____

DECLARATION

I, the undersigned, hereby revoke all my previous nominations and request the Fund, in the event of my death, to pay the lump sum death benefits payable by the Fund, to the following person(s) nominated overleaf, in the proportions indicated. I understand that my request remains subject to the conditions and regulations of the Rules of the Fund and the Pension Funds Act.

SIGNED AT _____

ON THIS _____ DAY OF _____

MEMBER'S SIGNATURE _____

WITNESS _____

NOTES

- Please complete a new nomination form if you wish to make any changes to your previous nomination.
- In terms of the Rules of the Fund, the benefits will be paid to dependants and / or nominees, depending on the circumstances at your death. "Dependant" means your spouse, your children, someone for whom you are (or may become) lawfully responsible for maintenance, as well as someone who actually depends on you for maintenance. A dependant or nominee must be a natural person.
- The information on this form is confidential and will be treated as such.
- Please provide the Fund with contact details i.e. addresses and phone numbers of dependants or nominees not living with you at your address, on the space provided.
- If you believe that there is any additional information of which the Trustees should be aware, please note this on the space provided.
- This form should be completed in legible writing (please print) and must be returned to the Fund.
- This form should always be updated and returned to the fund if any of your circumstances change, i.e. birth of a child, death of a spouse, etc.

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MEMBER NO. _____ SURNAME _____ FIRST NAMES _____

Dependants / Nominees

	A. Full Names	**B.** Relationship	**C.** Date of Birth	**D.** ID Number	**E.** Nature of Financial Dependence (if any)	**F.** % of Benefit	**G.** Residential Address	**H.** Contact Telephone Number
Dependants								
Nominees who are not dependants								
					Total	**100%**		

Trust Funds (Full details of beneficiary in respect of whom a Trust Fund has been created, is to be included under "Dependants / Nominees" above)

	Nominated Trust	Contact Details of Nominated Trust	**A.** Full Names of Beneficiary	**B.** Relationship of Beneficiary	**C.** Date of Birth of Beneficiary
Trust Funds					

Column A: Insert the person's surname and full names.
Column B: Indicate your relationship with the person, i.e. spouse, son, etc.
Column C: The date of birth should be indicated as follows: YYYY/MM/DD.
Column D: Insert the person's Identity Number.
Column E: State the nature of financial dependence (if any).
Column F: Indicate the % of the total benefit payable to the person i.e. 10%, 25%, etc. The total proportion must equal 100%.
Column G: Insert the person's full address, if not the same as yours.
Column H: Insert the person's contact phone number together with the area code, if not the same as yours.

ADDITIONAL INFORMATION: _____

SIGNED AT _____ ON THIS _____ DAY OF _____

MEMBER'S SIGNATURE _____ WITNESS _____

Hollard Group Risk

NOMINATION OF BENEFICIARY FORM

Please return to: Hollard Group Risk, 22 Oxford Road, Parktown, or PO Box 87428, Houghton 2041. Tel: (011) 351 5000, Fax: (011) 351 3262, email: hgradmin@hollard.co.za

WHEN TO COMPLETE THIS FORM

In the unfortunate event of an insured's death, many difficulties may present themselves if the insured has not left clear instructions regarding the distribution of the death benefit. In order to reduce unnecessary delays with the distribution of unapproved death benefits, please provide the details of the insured's nominated beneficiaries below.

It is recommended that the insured completes a new nomination of beneficiary form if any beneficiaries change or if the insured experiences any life-changing event (i.e. marriage, divorce, birth of a child, etc). This form may not be used for nomination of Retirement Fund beneficiaries. This form must be returned to the Human Resources department of the insured's employer. It will be the employer's responsibility to provide Hollard with information on the disposal of death benefits in the event of a claim.

INSURED'S PERSONAL DETAILS

First names		Surname	
Identity number		Date of birth	
Policyholder		Policy number	

BENEFICIARIES

Surname	First names	Date of birth	ID number	Relationship	% of benefit or Rand amount	Last known address	Last known contact number

DECLARATION (to be signed by the insured)

I fully understand that my circumstances and those of my beneficiaries may change. I accept the responsibility of updating my beneficiary details, should any changes be made. This beneficiary nomination form replaces all previous nomination forms completed by me.

Signed at: _____ on this: _____ day of: _____ 20 _____

_____

Signature