ELC PENSION FUND

ESTABLISHED BY UNITED EVANGELICAL LUTHERAN CHURCH IN SOUTHERN AFRICA

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FOR OFFICE USE ONLY

MEMBERSHIP NUMBER: _____

NEW MEMBER APPLICATION FORM

MEMBER'S PERSONAL DETAILS

TITLE: ☐ REV ☐ DR ☐ MR ☐ MRS ☐ MISS **SURNAME** _____

FIRST NAMES _____ **GENDER** ☐ MALE ☐ FEMALE

DATE OF BIRTH _____ **ID/PASSPORT NUMBER** _____

(Copy of this document must be attached)

COUNTRY OF ISSUE (if applicable) _____ **MARITAL STATUS** _____

NAME & SURNAME OF SPOUSE _____

SPOUSE'S DATE OF BIRTH _____ **SPOUSE'S ID/PASSPORT NUMBER** _____

INCOME TAX REF NO. _____

RESIDENTIAL ADDRESS _____

_____ **CODE** _____

POSTAL ADDRESS _____

_____ **CODE** _____

HOME TEL NO. _____ **WORK TEL NO.** _____

CELL PHONE NO. _____ **EMAIL ADDRESS:** _____

EMPLOYER DETAILS

NAME OF EMPLOYER _____

DATE OF COMMENCEMENT OF MEMBERSHIP OF THE FUND _____

OCCUPATION _____ **MONTHLY PENSIONABLE SALARY** _____

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 _____

NAME OF PREVIOUS FUND _____ **MEMBER NO** _____

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

PAID UP MEMBERSHIP CERTIFICATES

For every Fund that you have left and preserved your share in, you should have been issued with a Deferred Membership Certificate. Please list all such Fund's below and attach a copy of the Deferred Membership Certificate.

Name of Fund	Date of Withdrawal	Tick this column if you would like us to arrange to have this money transferred into the ELC Pension Fund

HEALTH QUESTIONNAIRE

1) **DID YOU CONSULT A DOCTOR DURING THE LAST 2 YEARS?** ☐ YES ☐ NO

If yes, please give full details: _____

2) **DO YOU SUFFER OR HAVE YOU EVER SUFFERED FROM ANY SERIOUS ILLNESS, DISEASE OR ABNORMALITY?** ☐ YES ☐ NO

If yes, please give full details: _____

3) **ARE YOU IN GOOD HEALTH AT PRESENT?** ☐ YES ☐ NO

If no, please give full details: _____

4) **HAVE YOU EVER BEEN TESTED FOR OR RECEIVED MEDICAL ADVICE, COUNSELLING OR TREATMENT IN CONNECTION WITH AIDS, AND AIDS RELATED CONDITION, HEPATITIS B OR ANY OTHER SEXUALLY TRANSMITTED DISEASE?** ☐ YES ☐ NO

If yes, please give full details: _____

DECLARATION

I, _____ employed by

_____

hereby warrant that all the information given above is true, complete and correct. I further irrevocably authorize ELC Pension Fund to request from any doctor, hospital, medical institution or any other person any information, including the results of any blood tests, which may be relevant to my physical or mental health, and I agree that this authorisation shall remain in force after my death as well as prior thereto.

I am familiar with and understand the rules of the ELC Pension Fund and agree that I am bound by them.

I authorise that the Fund may use the information provided by myself for purposes relevant to the administration of my benefits in terms of the Fund rules and applicable legislation.

I have attached the following documents to this application:

- ☐ A copy of my ID document or passport
- ☐ All Paid-up membership certificates (if applicable)

SIGNATURE OF EMPLOYEE _____ **DATE** _____

FULL NAME OF AUTHORISED OFFICIAL OF THE EMPLOYER _____

CONTACT NUMBER OF AUTHORISED OFFICIAL _____

SIGNATURE OF AUTHORISED OFFICIAL OF THE EMPLOYER _____

DATE _____ **EMPLOYER STAMP**

NOTES

- Please forward the New Members Application form to this office.
- The employee must complete a Beneficiary Statement which is to be forwarded to the Fund along with the Application Form.
- A copy of the employee's identity document must be attached to this form.