ELC PENSION FUND

ESTABLISHED BY UNITED EVANGELICAL LUTHERAN CHURCH IN SOUTHERN AFRICA

P.O. Box 101003, Scottsville, 3209
Tel: 033 845 9222/5
Fax: 033 845 9210
Email: gisela@elcsa.co.za or ilene@elcsa.co.za
Physical Address: 5 Connaught Rd, Scottsville, 3201

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 ID document must be attached)

MARITAL STATUS _____ **DATE OF MARRIAGE** _____

NAME & SURNAME OF SPOUSE _____

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

MARRIED IN OR OUT OF COMMUNITY OF PROPERTY? ☐ IN ☐ OUT

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** _____ _____

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.

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

DOCUMENTS

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