MULTILECT

Integrity. Trust. Choice.

INSTALLATION DOCUMENT

MULTILECT UMBRELLA PENSION & PROVIDENT FUNDS ("the Fund")

EMPLOYER DETAILS		
Registered Name of Participating Employer		
Physical Address		
Postal Address		
Telephone	Fax	E-mail

The following documents must accompany this form:

1. A resolution by the Employer on the Employer's letterhead
   (a) resolving to participate in the Fund, and
   (b) nominating and authorizing a person/s to act on behalf of the Employer in respect of the Employers participation in the fund.

2. Copy of Certificate of Incorporation.

FUND CHOICE

Choose a Fund by marking one of the boxes below with a X.

Multilect Umbrella Provident Fund ☐

Multilect Umbrella Pension Fund ☐

FUND STRUCTURE

Participation Date
Eligibility Conditions

Category of Members:

Category A:

Category B:

Category C:

Normal Retirement Age:

Category A: Age _____

Category B: Age _____

Category C: Age _____

Employer Contribution Rate:		Member Contribution Rate:	
Category A	_____ %	Category A	_____ %
Category B	_____ %	Category B	_____ %
Category C	_____ %	Category C	_____ %

Are contributions

Inclusive ☐ OR ☐ Exclusive of expenses, premiums and fees.

(Please mark a cross in the relevant box)

Alternative instruction for the deduction of expenses, premiums and fees:

INVESTMENT CHOICE	
Name of Investment Portfolio: Name of Investment Manager:	
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How are the contributions to be allocated:	
Portfolio:	Percentage:
1. _____	_____%
2. _____	_____%
3. _____	_____%
Investment Instructions – Other	

INSURED RISK BENEFITS
Basic Lump Sum Death Benefit
Other Lump Sum Benefits

COMMUNICATION		
By default all member communication will be sent to the Participating Employer. Please note that communication includes member benefit statements and other personal information of members.		
Please indicate if you would prefer this communication to be sent to the: *(Please tick the preferred option)*	Employer	Intermediary appointed to the scheme
Name of organization and contact person to receive communication if Intermediary:		
Telephone	Fax	E-mail
Physical Address		
Postal Address		

AUTHORISED PERSON AT COMPANY
The Employer must authorize a person to interact with the Fund, on behalf of the Employer, for the day to day administration of the Fund and members. The authorized person shall receive/provide documents and/or information to/from the Fund which may contain personal information. Personal information also includes passwords for members' access to web enabled benefit statements.
The Employer authorizes the following person/s:
(1) Authorized Person Full Name: ID Number: Tel Number: Cell Number: E-mail Address:

(2) Authorized Person

Full Name:

ID Number:

Tel Number: Cell Number:

E-mail Address:

TRANSFERS OF BENEFITS / ASSETS
Please complete this section if the Employer is transferring assets/benefits from another fund. *Transfers are processed in terms of section 14 of the Pension Funds Act; whereby a transfer requires the approval of the Registrar of Pension Funds.*
Name of previous fund
Name of administrator of previous fund
Contact Person at previous administrator Tel Number: E-mail:
Risk Benefit Underwriter

RESPONSIBLE PERSON FOR PAYMENT OF CONTRIBUTIONS
Name
Designation
E-mail Address
Telephone Number
Note: In terms of the Pension Funds Act certain persons are legally liable for the payment of contributions. Non-payment may result in a criminal offence. Responsible persons are defined as: *(a) for companies – Director involved in the management of the company's overall financial affairs* *(b) for closed corporations – Member involved in the management of the CC's overall financial affairs* *(c) Other employers – Person involved in the management of the employers overall financial affairs*

INTERMEDIARY APPOINTMENT AND COMMISSION		
Intermediary Corporate Name		
Intermediary Name		
Telephone Number	Cell Number	E-mail
Address		
Commission Payable		%
An intermediary may be a financial advisor, consultant, broker etc.		

DATA REQUIREMENTS
The following member information must accompany this document: (a) First Names (b) Surname (c) Date of Birth (d) ID Number (e) Tax Number (f) Pensionable Salary

I hereby confirm that I am authorized by the Employer to sign this document. I further confirm that the Employer will participate in the Fund and such participation will be in terms of the information provided in this document.

Full Name

Designation / Capacity

Signature

Date