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:<br>Name of Investment Manager: | |
| Name of Investment Portfolio:<br>Name of Investment Manager: | |
| Name of Investment Portfolio:<br>Name of Investment Manager: | |
| 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:<br>*(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**<br><br>Full Name:<br><br>ID Number:<br><br>Tel Number: Cell Number:<br><br>E-mail Address: |
| **(2) Authorized Person**<br><br>Full Name: |

| |
|---|
| ID Number:<br><br>Tel Number: Cell Number:<br><br>E-mail Address: |

| **TRANSFERS OF BENEFITS / ASSETS** |
|---|
| *Please complete this section if the Employer is transferring assets/benefits from another fund.*<br>*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<br><br>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:*<br>*(a) for companies – Director involved in the management of the company's overall financial affairs*<br>*(b) for closed corporations – Member involved in the management of the CC's overall financial affairs*<br>*(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