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Umbrella Retirement Fund

FUND MAINTENANCE FORM
RISK BENEFITS
AMENDMENT FORM

THIS FORM MUST BE SUBMITTED 1 MONTH PRIOR TO EFFECTIVE DATE.

UMBRELLA FUND NAME: _____

PARTICIPATING EMPLOYER NAME: _____

EFFECTIVE DATE: _____

EXECUTIVE SUMMARY OF REASON FOR CHANGE

_____

_____

_____

_____

TYPE OF AMENDMENT

Please select **ONE or MORE** of the following options:

☐ Premium change ☐ Insurer change ☐ Benefits change

RISK BENEFITS AMENDED

Please select **ONE or MORE** of the following options:

☐ Capital Disability ☐ Income Disability ☐ Life Cover

☐ Funeral Cover ☐ Other: _____

RISK BENEFIT PREMIUMS

Please note that the Funeral Cover Premium can either be expressed as a percentage of pensionable payroll or a fixed rand amount per member per month.

Risk Benefit Premiums included in Employer Contribution? ☐ YES ☐ NO

RISK BENEFITS	☑	CURRENT RATE	NEW RATE
Capital Disability Premium		%	%
Income Disability Premium		%	%
Life Cover Premium		%	%
Funeral Cover Premium			
Other			

☑ Please tick if premium based on Risk Salary instead on Pensionable Salary.
*Please provide proof of rate change as provided by product provider.

RISK BENEFITS

NOTE: PLEASE COMPLETE PER RISK POLICY AMENDED

Please select **ONE** of the following options:

☐ Capital Disability ☐ Income Disability ☐ Life Cover

☐ Funeral Cover ☐ Other: _____

POLICY DETAILS

POLICY NUMBER: _____

IF THERE IS A CLAIM AGAINST THE POLICY, TO WHICH PARTY WILL THE BENEFIT BE PAID DIRECTLY TO:-

☐ FUND (Approved / Reassured ie. Benefit from this policy stated in the Rules of the Fund)

☐ EMPLOYER / MEMBER / BENEFICIARY
(Unapproved / Free-standing ie. Benefit from this policy not stated in the Rules of the Fund)

PAYMENT OF POLICY PREMIUMS

THE EMPLOYER PAYS THE RISK PREMIUM:

☐ TO THE FUND (together with fund contributions)

☐ DIRECTLY TO THE INSURER (preferably free standing)

POLICY INSURER DETAILS

COMPANY

COMPANY NAME: _____

PHYSICAL ADDRESS: _____

_____

POSTAL ADDRESS: _____

_____

TELEPHONE NO.: _____ FAX NO.: _____

BANKING DETAILS

ACCOUNT NAME _____

BANK NAME _____

BRANCH NAME _____ BRANCH CODE _____

TYPE OF ACCOUNT _____ ACCOUNT NUMBER _____

BENEFIT SUMMARY

AUTHORISATION

CONSULTANT

FULL NAME: _____

COMPANY NAME: _____

SIGNATURE: _____ DATE _____

INTERNAL USE ONLY!!!

ADMINISTRATION MANAGER

APPROVED

FULL NAME: _____

SIGNATURE: _____ DATE _____