



Instructions:

Please fill in **BLOCK LETTERS** and return the hard copy to **PENSIONS ALLIANCE TRUST** office or send a scanned copy to clientservice@pensionsalliancetrust.com along with a copy of a photo National ID card.

CONTRIBUTOR'S NAME	SURNAME		OTHER NAMES		
	SURNAME		OTHER NAMES		
PREVIOUS NAME <small>(PLEASE ATTACH GAZETTE)</small>	SURNAME		OTHER NAMES		
	SURNAME		OTHER NAMES		
PERSONAL DETAILS	DATE OF BIRTH (DD/MM/YYYY)	AGE	GENDER (Tick Box) <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
	COUNTRY OF BIRTH	NATIONALITY	MARITAL STATUS		
	RESIDENTIAL ADDRESS		MAILING ADDRESS		
	RESIDENTIAL ADDRESS		MAILING ADDRESS		
IDENTIFICATION DETAILS	<input type="checkbox"/> Passport <input type="checkbox"/> Driver's Licence	ID NUMBER		SSNIT NUMBER	
	<input type="checkbox"/> Voter's ID <input type="checkbox"/> National ID	ID NUMBER		SSNIT NUMBER	
CONTACT DETAILS	E-MAIL ADDRESS		MOBILE NUMBER	LANDLINE	
	E-MAIL ADDRESS		MOBILE NUMBER	LANDLINE	
OTHER DETAILS	PLACE OF BIRTH	MOTHER'S NAME	FATHER'S NAME		
	DISTRICT / REGION	MOTHER'S ADDRESS	FATHER'S ADDRESS		
EMPLOYMENT DETAILS	OCCUPATION	INDUSTRY	COMPANY NAME		
	PREVIOUS EMPLOYER	PREVIOUS TRUSTEE	TRANSFER FUNDS (Tick Box) <input type="checkbox"/> NO <input type="checkbox"/> YES		
CONTRIBUTION DETAILS	ANNUAL BASIC SALARY	MONTHLY BASIC SALARY	5% MONTHLY CONTRIBUTION		
	ANNUAL BASIC SALARY	MONTHLY BASIC SALARY	5% MONTHLY CONTRIBUTION		

BENEFICIARY NOMINATION

I HEREBY NOMINATE THE PERSON(S) BELOW AS MY DEPENDANTS TO RECEIVE DEATH AND SURVIVAL BENEFITS IN THE EVENT OF MY DEATH:

NAME OF BENEFICIARY	DATE OF BIRTH	RELATION	PERCENTAGE ALLOCATION (100%)	RESIDENTIAL ADDRESS	CONTACT NUMBER

DECLARATION:

I declare and certify that:-

- 1) The facts herein stated are accurate and true;
- 2) Pensions Alliance Trust Limited will not be held liable for usage of the information provided on this form.

DATE: SIGNATURE / THUMBPRINT:

FOR OFFICE USE ONLY	DATE RECEIVED	OFFICIAL STAMP
DATE ENTERED	ENTRY OFFICER'S NAME & SIGNATURE	COMMENTS