

HEALTH SECTOR OCCUPATIONAL PENSION SCHEME

PENSIONS SERVICES ENGAGEMENT REQUEST FORM

EMPLOYER DETAILS		
1.	Name of Health Facility	
2.	Location Address	
3.	Postal Address	
4.	Office Telephone Number(s)	
5.	Fax Number (s)	
6.	Email Address	
7.	Facility Registration Number	
8.	Tax Identification Number of Facility	
9.	Social Security Number OF Health Facility (COMPLUSORY)	
EMPLOYER CONTACT PERSON DETAILS		
10.	Name of 1 st Contact Person (schedule officer)	
11.	Telephone Number (s)	
12.	Email Address	
13.	Name of 2 nd Contact Person	
14.	Contact Telephone Number (s)	
15.	Email Address	

DECLARATION

We warrant that the above statement and particulars are true. We hereby agree that this Declaration shall be held promissory and of continuing effect and shall form the basis of and be deemed to be incorporated in the Contract between us and the Enterprise Trustees Limited.

Official Stamp & Date _____ Signature (on Behalf of Employer) _____

FOR OFFICIAL USE ONLY

ASSIGNED FUND MANAGER

STAFF ASSIGNED TO WORK ON FORM

VIRTUAL ACCOUNT NUMBER

COMMENTS:

APPROVED BY:

POSTION:

SIGNATURE:

DATE: