Survivors Benefit Form for Health Sector Occupational Pension Scheme

Affix passport picture of deceased (Indicate Name behind picture)

NOTES:

(1) This Form is to be completed by any person who wishes to claim for payment of accrued benefits for a deceased person
*(2) Please use **BLOCK LETTERS** for completion of this Form*
(3) Please write "N/A" if not applicable
(4) Attach a photocopy of any valid ID (Voters ID, Passport, Driver's license)
(5) Attach all relevant documents under section IV based on the grounds for claiming accrued benefit
(6) The information given in this Form can be used by the Approved Trustee concerned and the National Pensions Regulatory Authority ("the Authority") in activities relating to the processing of the claim and may be disclosed to other parties for such purposes.

Complete where applicable using BLOCK letters or ☑

CLAIMANT SECTION – TO BE COMPLETED BY BENEFICIARY OF DECEASED EMPLOYEE

SECTION I – DETAILS OF THE CLAIMANT(S):

No.	Full Name(Sur/First/Middle Names)	Age:	Sex (F/M):	ID Type & No.	SNITT No.	P O Box	Mobile No.	Email Address	Relationship to Deceased
1									
2									
3									
4									
5									
6									

***Kindly include supplementary sheet to include additional beneficiary details if beneficiaries are more than seven.**

SECTION II – DETAILS OF THE CLAIM:

1. **SCHEME INFORMATION OF DECEASED AND ACCOUNT NUMBER(S) AGAINST WHICH PAYMENT(S) ARE CLAIMED:**

NOTE: The value that will be paid into the account(S) stated will be less bank charges relating to your payment.

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IDENTIFICATION & SCHEME INFORMATION OF DECEASED				
Name (*Full Name& Dob*):	*First:*	*Other:*	*Surname:*	Date Of Birth: [*DD/MM/YY*]
Scheme ID:	SSNIT Number:	Staff ID	Last Grade	
DETAILS OF DECEASED'S EMPLOYER				
Last place of Work/Facility/Institution Name:	Office Phone:	Fax:	Email:	
Location Address	Notable Land Mark	Postal Address		

2. **Preferred Method of payment**: (*Please tick '√' the appropriate box)*

Please note:

- All Beneficiaries must fill in their bank details
- Where you prefer to be paid by transfer, beneficiary must ensure that the bank account details supplied are in respect of th e **beneficiary's own account.**

No.	Account Name	Preferred Means of Payment(Chq/Transfer)	Account Number	Bank Name	Branch	Type of Account(savings/Current)
1						
2						
3						
4						
5						
6						

***Kindly include supplementary sheet to include additional beneficiary details if beneficiaries are more than six.**

NOTE: The value that will be paid into the account(S) stated will be less bank charges relating to your payment.

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Section III - Documents Enclosed

i. *Kindly Enclose **All** forms in the below Section* ***(Please tick '√' the appropriate box)***

☐ A copy of each claimant's ID card for verification of identity. ☐ A copy of deceased's ID card.

☐ A copy of deceased's beneficiary mandate signed with employer or Letter of Administration if deceased has no nominated beneficiary(s)

ii. *Kindly Enclose **ANY 3** of the below documents* ***(Please tick '√' the appropriate box)***

☐ Death Certificate, ☐ Medical Certificate of Cause of Death, ☐ Burial Permit, ☐ Mortuary Placement Documents ☐ Obituary

Section IV – Claimant(S) Declaration

1) *I / We* declare and certify that to the best of my/our * knowledge and belief, the information given in this Form and its attachments are correct and complete;*

2) *I / We* are duly informed and to my /our * full understanding that, I / we* will be liable to prosecution for any false declaration herein or hereafter made to the Scheme.*

3) I/We* agree that proceeds of the provident fund/personal pension scheme balance may be used to repay the loan owed to the employer of the deceased. We agree for Health Sector Occupational Scheme Trustees to pay the amount stated as outstanding liabilities be paid to the employer. We understand that such payment shall constitute a valid discharge to Enterprise Trustees.

No.	Full Name of beneficiary /Account Name	Preferred Means of Payment(Chq/Transfer)	Date[*DD/MM/YY*]	Signature of Beneficiary
1				
2				
3				
4				
5				
6				
7				

NOTE: The value that will be paid into the account(S) stated will be less bank charges relating to your payment.

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Section V – Employer Declaration

1. *We the employers of Mr./Miss/Mrs./ ..... Declare and certify that to the best of our knowledge and belief, the information given in this Form and its attachments is correct and complete;*
2. *We* are duly informed and to my /our * full understanding that, I / we* will be liable to prosecution for any false declaration herein or hereafter made to the Scheme.*

Beneficiary Details:

No.	NAME:	AGE:	RELATIONSHIP	% Split
1.				
2.				
3.				
4.				
5.				
6				
7.				

Employer Details:

Name of Facility/Institution		*Official Stamp of Organization**
Name of Head of Facility/Institution		
Contact No.	*Email **	
*Signature**	*Date*	

NOTE: The value that will be paid into the account(S) stated will be less bank charges relating to your payment.

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Section VI - Payment Instruction

Account Details- Member Benefits

a. Ensure that the bank account details supplied are in respect of beneficiary account
b. Note however that the value that will be paid into the account stated below will be less any outstanding bank charges relating to your payment.
c. Do make DOUBLE SURE that all account information is correct to prevent undue delays in the settlement of your benefit

Account Name*

*Account Number**

*Bank Name **

*Branch Name**

OFFICIAL USE ONLY

Section VII – Estimates of Amount of Benefit

Total Contributions made GH¢	Total Investment returns GH¢	Grand Total of Benefit due GH¢

Prepared by.....

Official Stamp.....

NOTE: The value that will be paid into the account(S) stated will be less bank charges relating to your payment.

SECTION VIII- BOARD OF TRUSTEES APPROVAL

<table>
<tr><td colspan="2">*Name of Board Member*</td><td rowspan="9">*Official Stamp of Organization**</td></tr>
<tr><td colspan="2">*Designation*</td></tr>
<tr><td>*Contact Number*</td><td>*Email **</td></tr>
<tr><td>*Signature**</td><td>*Date*</td></tr>
<tr><td colspan="2">*Name of Board Member*</td></tr>
<tr><td colspan="2">*Designation*</td></tr>
<tr><td>*Contact Number*</td><td>*Email **</td></tr>
<tr><td>*Signature**</td><td>*Date*</td></tr>
</table>

NOTE: The value that will be paid into the account(S) stated will be less bank charges relating to your payment.