PUBLIC SECTOR MEMBER ENROLMENT FORM

NATIONAL PENSIONS ACT, 2008 (ACT 766)

NAME OF MINISTRY: **MINISTRY OF HEALTH**

NAME OF SCHEME: **HEALTH SECTOR OCCUPATIONAL PENSION SCHEME**

TYPE OF SCHEME: **TIER 2**

KINDLY READ NOTES BEFORE COMPLETING FORMS

- *All fields are expected to be completed and should be completed using capital letters*
- *All fields with * are mandatory fields and must be provided*
- *Contributor /Employee staff number should be provided by all permanent staff*
- *Nature of Employment:* ***Permanent*** *Or* ***Casual***
- *Nature of Income:* ***Controller Or IGF***
- *Applicants are expected to sign the completed forms, members who are unable to sign should provide their thump prints*

CONTRIBUTOR STAFF ID*

MINISTRY CODE:

CONTRIBUTOR'S NAME	*SURNAME*		*FIRST NAME*		
	OTHER NAMES				
PREVIOUS NAME / MAIDEN NAME	*SURNAME*		*FIRST NAME*		
	OTHER NAMES				
DATE OF BIRTH *(*DD/MM/YYYY*)		**AGE**		**SEX**	
NATIONALITY				**MARITAL STATUS**	
PLACE OF BIRTH	***Town***	***District***	***Region***	**COUNTRY OF BIRTH**	

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PERMANENT ADDRESS			**MAILING ADDRESS**		
CURRENT CONTACT DETAILS	***MOBILE PHONE NUMBER****		***FIXED LINE***	***E-MAIL ADDRESS***	
IDENTIFICATION DETAILS	☐ **Passport** ☐ **Driver's Licence** ☐ **Voter's ID** ☐ **National ID**		***ID NUMBER***	***SOCIAL SECURITY NUMBER***	
NAME OF FATHER			**NAME OF MOTHER**		
FATHER'S ADDRESS			**MOTHER'S ADDRESS**		
PREVIOUS EMPLOYER (IF ANY)			**PREVIOUS CONTRIBUTOR ENROLLMENT NUMBER**		
NATURE OF EMPLOYMENT*			**NATURE OF INCOME**		
ANNUAL BASIC SALARY (GH¢)		**MONTHLY BASIC SALARY (GH¢)**		**5% CONTRIBUTION (GH¢)**	

INSTITUTION'S NAME*		**INSTITUTION'S CODE**	
INSTITUTION'S ADDRESS		**INSTITUTION'S TEL. NUMBER**	

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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 OF BENEFICIARY	CONTRIBUTOR ENROLLMENT NUMBER (IF ANY)	RELATIONS OF BENEFICARY TO CONTRIBUTOR	PERMANENT ADDRESS OF BENEFICARY	PERCENTAGE ALLOCATION TO BENEFICARY (To Total 100%)

DECLARATION:

I declare and certify that:-

1) ***I am not a member of any other similar scheme;***
2) ***I am not in possession of another Contributor Enrollment Number;***
3) ***the facts herein stated are accurate and true;***
4) ***I am duly informed and to my full understanding that, I will be liable to prosecution for any false declaration herein or hereafter made to the Scheme.***

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FINGER PRINT IDENTIFICATION

LEFT THUMB PRINT	RIGHT THUMB PRINT
OTHER PRINTS WHERE THERE IS NO THUMB OR UNCLEAR FINGER PRINT MARKS	OTHER PRINTS WHERE THERE IS NO THUMB OR UNCLEAR FINGER PRINT MARKS
INDICATE WHICH FINGER	INDICATE WHICH FINGER

DATED: ……

SIGNATURE OR MARK OF CONTRIBUTOR: …… (MARK)

DECLARATION BY ENROLLMENT OFFICER

I certify that this Contributor Enrollment Form was completed in my presence and under my supervision and that information herein contained is certified to be accurate and true.

NAME OF ENROLLMENT OFFICER **SIGNATURE**

…… ……

……

OFFICIAL STAMP OF SPONSORING EMPLOYER