SECURE PENSIONS OCCUPATIONAL MASTER TRUST SCHEME
BENEFICIARY CLAIM FORM

FORM NUMBER: SPOMTS 3-5

PLEASE COMPLETE THIS FORM IN BLOCK LETTERS

APPLICATION FOR WITHDRAWAL OF ACCRUED BENEFIT

CLAIMANT'S PERSONAL DETAILS

TITLE	FIRST NAME	MIDDLE NAME	SURNAME

POSTAL ADDRESS

CONTACT NUMBER(S) | **EMAIL ADDRESS**

GENDER (Please tick)		RELATIONSHIP TO MEMBER	ID TYPE & ID NUMBER (Attach copy of ID)
MALE	FEMALE		

IF CLAIM IS ON BEHALF OF MINOR WHO IS A BENEFICIARY, PLEASE PROVIDE MINOR'S DETAILS BELOW

FIRST NAME	MIDDLE NAME	SURNAME	DATE OF BIRTH (DD/MM/YYYY)

GENDER (Please tick)		RELATIONSHIP TO MEMBER	RELATIONSHIP TO CLAIMANT	BIRTH CERT. No. (Attach copy)
MALE	FEMALE			

SCHEME MEMBER'S DETAILS

TITLE	FIRST NAME	MIDDLE NAME	SURNAME

SOCIAL SECURITY NUMBER | **SCHEME MEMBERSHIP ID** | **DATE OF BIRTH (DD/MM/YYYY)**

GENDER (Please tick) | **NAME OF LAST EMPLOYER**

MALE FEMALE

TYPE OF BENEFIT APPLIED FOR (PLEASE TICK APPROPRIATE BOX)

☐ SURVIVOR'S BENEFIT

☐ OTHER (PROVIDE DETAILS BELOW)

PAYMENT DETAILS

ACCOUNT NAME | **ACCOUNT NUMBER**

BANK | **ACCOUNT HOLDING BRANCH**

DECLARATION BY CLAIMANT

I CERTIFY THAT THE FACTS STATED ABOVE ARE TO THE BEST OF MY KNOWLEDGE TRUE AND ACCURATE

CLAIMANT'S SIGNATURE | **DATE OF REQUEST**

FOR OFFICIAL USE ONLY

CONFIRMATION FROM EMPLOYER

☐ YES

☐ NO

ACCOUNT MANAGER

SIGNATURE

CONFIRMATION DATE

ADDITIONAL DOCUMENTS REQUIRED

ACCRUED BENEFIT PAYABLE

PROPORTION	AMOUNT (GH₵)	DATE OF APPROVAL

NAME OF AUTHORISED OFFICER | **SIGNATURE**

NAME OF AUTHORISED OFFICER | **SIGNATURE**