



# SUPERANNUATION FUND MEMBER ENROLMENT FORM

FORM SFMEF-102025

PLEASE TYPE OR WRITE IN BLOCK CAPITALS

NAME OF SUPERANNUATION FUND: \_\_\_\_\_ DIVISION: \_\_\_\_\_

Title: _____	First Name: _____	M.I: _____	Last Name: _____	DOB: (dd/mm/yyyy) _____
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			TRN: _____
Residential Address: _____			Tel (H): _____	
Mailing Address: _____			Tel (W): _____	
Personal Email Address: _____			Tel (C): _____	
Position: _____		Employee #: _____	Department/Branch: _____	

## SALARY & CONTRIBUTION

State the % contribution that you are authorizing your employer to deduct from your earnings.

Gross Annual Salary	J\$	Basic Contribution (Mandatory)	5%	Voluntary Contribution Rate (Up to 10%)		Total Contribution Rate (Up to 15%)	
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## TRANSFER OF FUNDS

Complete if transferring benefits from another Approved Retirement Scheme or Superannuation Fund.

Note: Info may need to be requested from previous employer.

Name of Plan	Type of Plan	FSC Registration #	Date Joined	Termination Date	Funds Transferred In
	<input type="checkbox"/> Retirement Scheme <input type="checkbox"/> Superannuation Fund		(dd/mm/yyyy)	(dd/mm/yyyy)	J\$
	<input type="checkbox"/> Retirement Scheme <input type="checkbox"/> Superannuation Fund		(dd/mm/yyyy)	(dd/mm/yyyy)	J\$

## MEMBER'S BENEFICIARY INFORMATION

BENEFICIARY NAME	RELATION	DOB	%	TRN	ADDRESS	CONTACT NO.
		(dd/mm/yyyy)				
		(dd/mm/yyyy)				
		(dd/mm/yyyy)				
		(dd/mm/yyyy)				
		(dd/mm/yyyy)				

PLEASE NOTE: The allocation total must equal to 100%. The beneficiaries listed above are deemed to be revocable beneficiaries unless otherwise stated. If any of the beneficiaries are under 18 years of age, an adult must be appointed as trustee.

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**TRUSTEE INFORMATION****PLEASE TYPE OR WRITE IN BLOCK CAPITALS**

TRUSTEE NAME	TRUSTEE FOR	ADDRESS	TRN	CONTACT NO.

**DECLARATION**

1. I authorize my Employer to deduct contributions from my salary at the Total Contribution Rate identified above.
2. I authorize that the persons named above to be the beneficiary/beneficiaries of my pension contributions plus all interest credited to my account, and any other benefits due to me, as a member of the fund.
3. I reserve for myself the right to change my instructions by informing my Employer in writing and completing the Member Update Form.
4. I confirm that the information provided is true, correct and complete to the best of my knowledge and authorize the JMMB Administrator to effect same.
5. I undertake to comply with the rules of the fund.

Signature of Employee: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Witness: \_\_\_\_\_ Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_\_

**FOR EMPLOYER'S USE ONLY**

Member's Date of Employment:	Member's Date of First Contribution:	Member's Date of Confirmation:

Name of HR Representative	Signature of HR Representative	Date