# INDIVIDUAL SAVINGS AND RETIREMENT PLAN MEMBERSHIP APPLICATION FORM

Please complete the form in capital letters only and every section marked with asterisk (*)

Please provide copies of your:

1. National ID Card/Passport
2. KRA PIN Certificate
3. Image of the front face of your ATM card / Crossed Cheque/a page of your Bank Statement showing your name and account number

## *SECTION 1: STATIC DATA AND CONTACT INFORMATION

Kindly provide your static data and contact information:

Name _____ _____ _____
*(Surname)* *(First Name)* *(Middle Name)*

National ID No. / Passport No. _____ Gender: ☐ Male ☐ Female

Date of Birth _____ Mobile No._____
*(DD/MM/YYYY)*

Preferred Retirement Age _____ Years KRA PIN _____

Email Address _____

Source of Funds: ☐ Retirement Benefits Transfers In ☐ Employment Income ☐ Business Income

☐ Grant ☐ Other *(specify)*_____

Name of Employer / Type of Business / Other _____

_____

## *SECTION 2: RETIREMENT BENEFITS (PLEASE NOTE THIS IS THE DEFAULT PRODUCT)

Contribution Amount (Kshs) _____

Frequency of Contribution: *(please tick as preferred)*

☐ Single/Transfer In ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Preferred Mode of Contribution: *(please tick as preferred)*

☐ Mobile Money ☐ Credit Card ☐ Direct Debit ☐ Check-off ☐ Cheque

Account/Credit Card Name _____

Account/Credit Card Number_____

Bank _____Branch _____

Mobile Number_____

Mobile Money Registered Name_____

If Check-off, Name of your Employer_____

_____

## *SECTION 3: PERSONAL BANK/PAYMENT DETAILS

Kindly provide your bank account or mobile money details where you would wish to receive your benefits in future. Kindly remember to update any changes to these details.

Account / Credit Card Name _____ Bank_____

Account / Credit Card Number _____ Branch_____

Mobile Money Registered Name _____ Mobile No. _____

## SECTION 4: PENSION BENEFITS TRANSFERS IN

You can consolidate all other retirement benefits that you have deferred in other Pension Plans to this Plan by transferring in those benefits. To transfer in the benefits please share with us the details of those benefits below and also complete the Benefits Transfers In Form in duplicates and submit the first copy with the Trustees or Administrator of the Retirement Benefits Plans where the other benefits are and the second copy to us. The first copy of the Benefits Transfers In Form will act as the instructions to Trustees to transfer your benefits to this Plan.

Member No. / Unique identifier_____

Name of Retirement Benefits Plan / Scheme / Fund _____

Name of Scheme Administrator _____

Approximate Amount to be transferred in (Kshs) _____

## SECTION 5: NOMINATION OF BENEFICIARIES

In the table below kindly nominate the persons you would like to be considered as beneficiaries for receiving any pension benefits payable in your respect in the unfortunate event of your death:

| Name of Beneficiary | Relationship | Date of Birth (dd/mm/yyyy) | National ID No. / Birth Certificate No. | Contact Details (Postal address or Mobile No.) | Percentage Allocated (%) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

If any of the beneficiaries nominated above are minors (below 18 years) or require legal guardianship, kindly nominate a person to act as their legal guardian in the unfortunate event of your death. Please note the legal guardian will not be entitled to any benefits.

Guardian's Name _____ _____ _____

*(Surname)* *(First Name)* *(Middle Name)*

National ID No. / Passport No. _____ Date of Birth_____

*(DD/MM/YYYY)*

Mobile Number_____ Relationship _____

You may also nominate a Trust Fund through which you would wish the minor'(s) benefits administered in the unfortunate event of your death.

Name of Trust Fund _____

## DECLARATION

I hereby declare that the statements made by me in this form are, to the best of my knowledge and belief, complete and true. The Plan undertakes to deal with this information in strict confidence and in line with the Data Protection Act and Regulations.

I acknowledge and consent to the processing of the following data categories:

1. Data in the form of personal identification documents and numbers (legal obligation).
2. Data concerning contribution amounts, frequency, bank accounts and beneficiaries, which are required to fulfil this contract.
3. Data concerning data subjects telephone number and e-mail address to enable communication pertaining to my account(s).

I am aware that I can exercise my data subject rights to access, object, rectify, erase and to be informed by accessing the Privacy Notice and Privacy Policy, which can be found on the Equity Group Holdings' website at https://equitygroupholdings.com and by sending a request to the controller by e-mail to dpo@equityinsurance.co.ke. I further authorize Equity Life Assurance (K) Limited to share my information with persons, agents and third parties, who act on behalf of Equity Life Assurance (K) Limited, subsidiaries of the Equity Group or use any of my information domiciled with them, if it enables Equity Life Assurance (K) Limited to service my account(s) better.

Name _____ Signature _____ Date _____