METROPOLITAN PENSIONS TRUST
Together We Can!

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WITHDRAWAL FORM

1. Member Details

Employer Name: **Scheme Type:** Tier 2: ◯ Tier 3: ◯

Member Surname: Employer Number:

Member First Names:

Date of Birth: D D M M Y Y Y Y Social Security Number:

Member Residential Address:

Member Postal Address:

Email Address:

Date of Employment: D D M M Y Y Y Y Date of Last Contribution: D D M M Y Y Y Y

Telephone/Mobile Number: 1 2

Indebtedness to employer to be recovered from benefits. YES ◯ NO ◯ Amount GHC

2. Withdrawal Type

Retirement: ☐ Resignation: ☐ Partial Withdrawal: ☐ Death: ☐ Emigration: ☐ Disability: ☐ Transfer: ☐

Dismissal/Termination: ☐ Retrenchment: ☐ Full Withdrawal: ☐ Other (specify):

3. Payment Instruction (Payment and Distribution of Document)

Full Benefit to be paid to member: ☐ Full Benefit to be transferred to another approved fund: ☐

Part paid to member and part to another approved fund: ☐

****Benefit to member**** (complete this section if full/part benefit is to be paid to member)

Partial Withdrawal Amount/Percentage (applicable for partial withdrawal and transfers):

Account holders Name:

Name of Bank: Type of Account:

Account Number: Name of Branch:

****Transfer to Another Approved Scheme**** (complete this section if full/part benefit is to be paid to another approved scheme)

Transfer Amount/Percentage (applicable for transfers):

Name of Trustee:

Scheme Name:

Scheme Account Name: Scheme Account Number:

Name of Bank: Name of Branch:

****Death**** (complete this section for **ONLY DEATH** claims)

Beneficiary's Surname: Beneficiary's First Names:

Date of Birth: D D M M Y Y Y Y Telephone/Mobile Number:

Beneficiary's Address:

Email Address: Relationship to Deceased:

Beneficiary's Account Name:

Beneficiary's Account Number: Name of Bank:

Type of Account: Name of Branch: Branch Code:

4. Member/Beneficiary Signature & Discharge

I declare that:

- payment of my benefit as specified herein represents the full and final discharge of the Fund's liability to me as set out in the rules of the Fund;
- the details provided herein are true and correct in every way;
- I understand the options available to me with regard to the payment of my benefits, including the tax implications and that I am making an informed choice;
- in the event of any loss suffered as a result of any details provided herein being incorrect, neither the Fund nor Metropolitan can be held liable for such losses.

Member/Beneficiary Signature:

Date: D D M M Y Y Y Y

5. Employers Declaration

The employer declares that:

- the information contained herein is correct;
- it shall indemnify the Fund and Metropolitan against any loss, damages, cost and expenses which the beneficiaries and or the Fund may sustain as a result of Metropolitan or the Fund relying on the information herein.

Employer Stamp:

Name:

Designation:

Authorized Signature:

Date: D D M M Y Y Y Y

IMPORTANT

- **For death claims, kindly ensure that the following are attached to your claim.**
  A copy of claimant's ID card, A copy of deceased's ID card, Letter of Administration and either Death Certificate, Medical Certificate of Cause of Death, Burial Permit, Mortuary Placement Document or Obituary
- **For emigration claims, kindly ensure that the following are attached to your claims.**
  A copy of claimant's ID card, an emigration confirmation letter from employer, a statutory declaration, and copy of passport
- **For termination/dismissal/retrenchment claims, kindly ensure that the following are attached to your claim.**
  A copy of claimant's ID card, a letter from employer confirming terminations/dismissal/retrenchment