



WOOLWORTHS GROUP RETIREMENT FUND

MAKING THE DIFFERENCE TO YOUR RETIREMENT

NOMINATION OF BENEFICIARY

If you die, this form lets us know to which beneficiaries your death benefits must be paid, and what percentage to pay to each beneficiary.

Surname	<input type="text"/>																												
First Name	<input type="text"/>																												
ID Number	<input type="text"/>														Employee No.	<input type="text"/>													
Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Store/Branch	<input type="text"/>																							
Home Address	<input type="text"/>																												
	<input type="text"/>																												

YOUR BENEFITS

RETIREMENT FUND GROUP LIFE ASSURANCE BENEFIT (GLA)

- As a member of the Woolworths Group Retirement Fund, you have the **Retirement Fund Group Life Assurance Benefit**. This benefit is subject to the terms and conditions as stipulated in the Fund's rules
- The trustees of the pension fund **distribute between one times (1x) and four times (4x) your annual pensionable salary** (depending on your membership) **plus your retirement fund savings (Fund Credit)** to your beneficiaries. This benefit is subject to tax. Non-contributing members only have their Fund credit available.
- **For this benefit, the Nomination of Beneficiary form is used AS A GUIDE for the trustees and the distribution may not be the same as your nomination.** The trustees will consider your nomination form and other factors as set out in the Pension Fund Act when deciding how the death benefit will be distributed.

IF YOU ARE AGE 53 OR OLDER, you may elect to reduce your cover to **two times (2x) your annual pensionable salary plus your retirement fund savings (Fund Credit)**. This reduces the cost of life insurance and increases the contributions allocated towards your retirement savings.

EMPLOYER-PROVIDED LIFE INSURANCE BENEFIT

- This additional benefit is paid to your beneficiaries in the event of your death or permanent disability.
- This insurance policy pays out **two times (2x) your annual pensionable salary** to your beneficiaries. This payment is tax free.
- You cannot change the level of cover of this benefit.
- **For this benefit, your Nomination of Beneficiary form is binding on the insurer and the benefits must be distributed according to your wishes.**

NOMINATE YOUR BENEFICIARIES

RETIREMENT FUND GROUP LIFE ASSURANCE BENEFIT (GLA)

EMPLOYER-PROVIDED LIFE INSURANCE BENEFIT

- You may nominate the same beneficiaries for both benefits (tick both).
- If you nominate different beneficiaries for each benefit, please submit one form per benefit.
- If you are nominating different beneficiaries, tick one benefit (Retirement Fund GLA or Employer-Provided Life Insurance benefit) for which your nominees will apply.

BENEFICIARY 1	Percentage:	BENEFICIARY 2	Percentage:
Relationship to Employee:		Relationship to Employee:	
Surname:		Surname:	
First Name:	Male <input type="checkbox"/> Female <input type="checkbox"/>	First Name:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:		Address:	
	Postal Code:		Postal Code:
Contact Numbers:		Contact Numbers:	
ID Number:		ID Number:	
BENEFICIARY 3	Percentage:	BENEFICIARY 4	Percentage:
Relationship to Employee:		Relationship to Employee:	
Surname:		Surname:	
First Name:	Male <input type="checkbox"/> Female <input type="checkbox"/>	First Name:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:		Address:	
	Postal Code:		Postal Code:
Contact Numbers:		Contact Numbers:	
ID Number:		ID Number:	
BENEFICIARY 5	Percentage:	BENEFICIARY 6	Percentage:
Relationship to Employee:		Relationship to Employee:	
Surname:		Surname:	
First Name:	Male <input type="checkbox"/> Female <input type="checkbox"/>	First Name:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:		Address:	
	Postal Code:		Postal Code:
Contact Numbers:		Contact Numbers:	
ID Number:		ID Number:	
Employee Signature	<input type="text"/>		Date <input type="text"/>

Ensure that your nominated beneficiaries are aware that you are providing their information to us for this purpose.

PLEASE SEND THIS COMPLETED FORM TO YOUR HRA

FOR INTERNAL USE:	
HRA Name	<input type="text"/>
Signature	<input type="text"/>
Date Actioned on Peoplesoft	<input type="text"/>