



WOOLWORTHS GROUP RETIREMENT FUND

MAKING THE DIFFERENCE TO YOUR RETIREMENT

NOMINATION OF BENEFICIARY

Surname																											
First Name														Employee No.													
Store/Branch							Home Address																				

- When you die, this form lets us know which beneficiaries your **Group Life Assurance** benefit must be paid to, and what percentage to pay each beneficiary. Your Group Life Assurance benefit is 2 x your Annual Pensionable Salary.
- The trustees of the pension fund distribute your **4 x (or 2 x if you are over age 53 and elected this option) Annual Pensionable Salary** and **Fund Credit** to your financial dependants.
- This Nomination of Beneficiary form is merely a guide for the trustees and does not mean the distribution will be the same.
- Please express your wishes by completing this form and sending it to your HRA.
- Ensure that your nominated beneficiaries are aware that you are providing their information to us for this purpose.

BENEFICIARY 1	Percentage:	BENEFICIARY 2	Percentage:
Relationship to Employee:		Relationship to Employee:	
Surname:		Surname:	
First Name: <input type="checkbox"/> Male <input type="checkbox"/> Female		First Name: <input type="checkbox"/> Male <input type="checkbox"/> Female	
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: <input type="checkbox"/> Male <input type="checkbox"/> Female		First Name: <input type="checkbox"/> Male <input type="checkbox"/> Female	
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: <input type="checkbox"/> Male <input type="checkbox"/> Female		First Name: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:		Address:	
Postal Code:		Postal Code:	
Contact Numbers:		Contact Numbers:	
ID Number:		ID Number:	
Employee Signature			Date
		D D M M Y Y Y Y	

PLEASE SEND THIS COMPLETED FORM TO YOUR HRA

FOR INTERNAL USE:																											
HRA Name																											
Signature														Date Actioned on PeopleSoft													