

De Beers Pension Fund – DC Section and Benefit Society

Prospective permanent employees to complete relevant details and to hand to the doctor at the time of his/her medical for completion
Note: Pension Fund members to complete and attach Beneficiary nomination form (M9.1) and Sworn declaration (M11.1)

PLEASE NOTE THAT ONLY ORIGINAL FORMS ARE ACCEPTED BY THE FUND

SECTION A - TO BE COMPLETED BY COMPANY (EMPLOYER)			
NAME OF COMPANY		OPERATION	
ADDRESS OF COMPANY			
DATE EMPLOYEE ENGAGED BY COMPANY			

SECTION B - TO BE COMPLETED BY COMPANY (EMPLOYER)			
MEMBER PARTICULARS			
IS MEMBERSHIP OF DE BEERS BENEFIT SOCIETY REQUIRED?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
If yes, please complete:			
DATE EMPLOYEE IS TO JOIN THE SOCIETY			
Total Remuneration Package (TRP)	<input type="checkbox"/>	Benefit Value	R
Non TRP	<input type="checkbox"/>	Basic Salary	R
INCOME CATEGORY (CATEGORIES A TO G)			
IS MEMBERSHIP OF DE BEERS PENSION FUND – DC SECTION REQUIRED?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
If yes, please complete:			
DATE EMPLOYEE IS TO JOIN THE FUND			
Total Remuneration Package (TRP)	<input type="checkbox"/>	Monthly Pensionable Earnings	R
Non TRP	<input type="checkbox"/>	Basic Salary+85% car allow+HLA	R

NOTE: A certified copy of the member's ID must be attached to this form.			
MEMBERSHIP (PENSION) NUMBER ISSUED BY EMPLOYER			
EMPLOYEES COMPANY NUMBER			
SURNAME			
INITIALS			
FIRST NAMES			
PREFERRED NAME			
TITLE (PROF / DR / MR / MRS / MISS)			
E-MAIL ADDRESS :			
Where e-mail addresses are supplied , all Fund communication will be directed to the e-mail address supplied			
DATE OF BIRTH			
GENDER			
MARITAL STATUS			
PREFERRED LANGUAGE			
NATIONALITY			
IDENTITY NUMBER			
PASSPORT NUMBER IF AVAILABLE			
IF PASSPORT, COUNTRY OF ISSUE			
INCOME TAX NUMBER (mandatory)			
POSTAL ADDRESS		CODE	
PHYSICAL ADDRESS		CODE	
TELEPHONE NUMBER (H)		TELEPHONE NUMBER (W)	
CELLPHONE NUMBER		FAX NUMBER	
ADDRESS OF FAMILY MEMBER NOT LIVING AT SAME ADDRESS		CODE	
TO WHAT TRADE UNION DOES MEMBER BELONG? (IF APPLICABLE)			

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STATE THE EMPLOYEE'S PREVIOUS MEDICAL AID DETAILS						
NOTE: Please attach certificate of previous medical aid membership						
NOTE: Waiting periods may be imposed, unless a certificate of membership is attached proving transferability						
25	DE BEERS		FROM		TO	
26	OTHER (SPECIFY)		FROM		TO	
	OTHER'S ADDRESS					
	PREVIOUS MEDICAL AID MEMBERSHIP NUMBER					
STATE THE EMPLOYEE'S PREVIOUS PENSION FUND DETAILS						
27	M.O.P.F. / M.E.P.F		FROM		TO	
28	TO DE BEERS		FROM		TO	
29	OTHER (SPECIFY)		FROM		TO	
	OTHER'S NAME					
	OTHER'S ADDRESS					
	PREVIOUS PENSION FUND MEMBERSHIP NUMBER					

SECTION C - TO BE COMPLETED BY COMPANY (EMPLOYER)							
DEPENDANTS' PARTICULARS							
NOTE: PLEASE INDICATE IF MEMBERSHIP TO BENEFIT SOCIETY FOR SPOUSE AND/OR CHILDREN IS REQUIRED, BY ENTERING "Y" OR "N" IN THE SPACE PROVIDED.							
FOR SPOUSE, A CERTIFIED COPY OF I.D. & MARRIAGE CERTIFICATE MUST BE ATTACHED.							
FOR LIFE PARTNER, A CERTIFIED COPY OF I.D. & AFFIDAVIT FOR REGISTRATION OF LIFE PARTNER WITH SUPPORTING DOCUMENTATION MUST BE ATTACHED.							
FOR CHILDREN, CERTIFIED COPIES OF I.D.'S AND / OR BIRTH CERTIFICATES MUST BE ATTACHED.							
1. SPOUSE (POLYGAMOUS MARRIAGES IN SENIORITY PLEASE) AND/OR LIFE PARTNER							
Benefit society use only INTERNAL NUMBER	Y/N	INITIALS	FIRST NAMES	DATE OF MARRIAGE	DATE OF BIRTH	MAIDEN SURNAME	PREVIOUS SURNAME IF DIVORCED
2. CHILDREN							
Benefit society use only INTERNAL NUMBER	Y/N	INITIALS	FIRST NAMES	DATE OF BIRTH	GENDER	STATE IF OWN, STEP OR ADOPTED CHILD	SURNAME IF DIFFERENT FROM MEMBER
SECTION D - TO BE COMPLETED BY COMPANY (EMPLOYER)							
SUNDRY PARTICULARS							
HAS THE MEMBER WORKED FOR DE BEERS BEFORE?				STATE YES OR NO			
IF YES	A	WHERE					
	B	FROM	TO				
HAS THE MEMBER WORKED FOR THE A.A.C. GROUP BEFORE?				STATE YES OR NO			
IF YES	A	WHERE					
	B	FROM	TO	TO			
NAME AND ADDRESS OF PREVIOUS EMPLOYER				MARRIED FEMALE EMPLOYEES, PLEASE STATE NAME, ADDRESS AND MEMBERSHIP NUMBER OF HUSBAND'S MEDICAL AID			
SPOUSE'S MEDICAL AID IS DE BEERS, STATE THE POLICY MEMBERSHIP NUMBER							

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SECTION E - TO BE COMPLETED BY MEMBER									
HAS THE APPLICANT OR ANY OF HIS/HER DEPENDANTS EVER SUFFERED FROM ANY OF THE FOLLOWING PROBLEMS? STATE CLEARLY "YES" OR "NO". IF "YES" GIVE THE YEAR THE PROBLEM ORIGINATED AND WHO IT WAS WHO SUFFERED FROM THE PROBLEM. THE BENEFIT SOCIETY RESERVES THE RIGHT TO INDEMNIFY THEMSELVES AT A LATER DATE SHOULD ANY OMISSIONS OR INACCURACIES BE MADE IN THIS DECLARATION.									
		Y/N	YEAR	NAME			Y/N	YEAR	NAME
1	BACK PROBLEMS				17	DIABETES			
2	SKIN DISEASES				18	SKELETAL DISEASES/DEFECTS			
3	EYE DISEASES/DEFECTS				19	ULCERS			
4	EAR DISEASES/DEFECTS				20	HERNIAS			
5	EPILEPSY or FITS				21	KIDNEY/BLADDER COMPLAINTS			
6	A.I.D.S., H.I.V.+				22	RHEUMATISM			
7	NERVOUS OR MENTAL DISEASES INCLUDING STRESS OR DEPRESSION				23	RHEUMATIC FEVER			
8	RESPIRATORY DISEASES / DEFECTS				24	SILICOSIS			
9	TUBERCULOSIS				25	STOMACH COMPLAINTS			
10	DIGESTIVE DISEASES/DEFECTS				26	HEART/BLOOD DISEASES/DEFECTS			
11	ANY OPERATIONS OR HOSPITAL ADMISSIONS				27	ANY BROKEN BONES			
12	GENITAL ORGAN DISEASES/DEFECTS				28	CHEST DISEASES/DEFECTS			
13	NOSE DISEASES/DEFECTS				29	DRUG PROBLEMS			
14	THROAT DISEASES/DEFECTS				30	ALCOHOL PROBLEMS			
15	ARTHRITIS				31	PREGNANCY			
16	CANCER				32	ANY OTHER MEDICAL CONDITION NOT COVERED ABOVE			
MEDICAL OFFICER'S COMMENTS ON ANY AFFIRMATIVE ANSWERS GIVEN ABOVE:									
Leading questions to be asked by the medical officer include:									
(1) Were you hospitalized and if so, for how long?									
(2) When did you last consult a doctor relating to this problem?									
(3) Are you still on medication for this problem?									
(4) Have any of your family suffered from any unusual diseases?									
(5) Have any of your brothers or sisters died?									
MEDICAL OFFICER'S SIGNATURE:									
FAMILY HISTORY		Name			Date of Birth		If deceased, year of death & cause of death		

