



Rollover and Allocated Pension Plan

Nomination of Beneficiary

Please complete in capital letters and in BLACK INK only

Use this form ONLY if you wish to pay your benefits to your legal personal representative (dependant) on your death.

Nomination of your dependant is optional. Where a nomination has not been made, any remaining account balance will be paid by the Trustee to your spouse (either legal or de facto) or to your Estate where you are not survived by a spouse. For further information, please refer to the Product Disclosure Statement (PDS).

The Trustee is not bound by this nomination, but will give it due consideration in determining the beneficiaries to be paid the benefit in the event of the members death.

Please ensure that you have first read the "Important Notes for Members" before completing this form.

1. Your details

Member no.	<input type="text"/>	Date of birth (dd/mm/yyyy)	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>
Title	<input type="text"/> (e.g. Mr/Mrs/Ms/Miss/Dr)						
Family name	<input type="text"/>						
Given name(s)	<input type="text"/>						
Street/PO Box no.	<input type="text"/>						
Suburb/Town/City	<input type="text"/>						
State/Territory	<input type="text"/>	Postcode	<input type="text"/>	Country (if outside Australia)	<input type="text"/>		
Phone: Home no. (inc. STD/ISD)	<input type="text"/>			Business no. (inc. STD/ISD)	<input type="text"/>		
Mobile no.	<input type="text"/>			Fax no. (inc. STD/ISD)	<input type="text"/>		
E-mail address	<input type="text"/>						

2. Nomination of dependant(s)

Dependant #1								
Title	<input type="text"/> (e.g. Mr/Mrs/Ms/Miss/Dr)	Benefit Application Percentage:	<input type="text"/>					%
Full name	<input type="text"/>							
Street/PO Box no.	<input type="text"/>							
Suburb/Town/City	<input type="text"/>							
State/Territory	<input type="text"/>	Postcode	<input type="text"/>	Country (if outside Australia)	<input type="text"/>			
Phone no. (inc. STD/ISD)	<input type="text"/>			Relationship:	<input type="text"/>			
Dependant #2								
Title	<input type="text"/> (e.g. Mr/Mrs/Ms/Miss/Dr)	Benefit Application Percentage:	<input type="text"/>					%
Full name	<input type="text"/>							
Street/PO Box no.	<input type="text"/>							
Suburb/Town/City	<input type="text"/>							
State/Territory	<input type="text"/>	Postcode	<input type="text"/>	Country (if outside Australia)	<input type="text"/>			
Phone no. (inc. STD/ISD)	<input type="text"/>			Relationship:	<input type="text"/>			



Please notify the Trustee in the event of any change in the details of your Dependant(s).

TO BE VALID, THIS FORM MUST BE SIGNED BY YOU, DATED AND WITNESSED

Signed

Date (dd/mm/yyyy) / /

Witnessed by:

Full name

Signed

Date (dd/mm/yyyy) / /

IMPORTANT NOTES FOR MEMBERS

BENEFIT APPLICATION PERCENTAGE

Should you wish to nominate more than one dependant, then you need to specify the percentage of your death benefits to be paid to each dependant. If you wish to make a more detailed nomination please contact Member Services.

WITNESS DEFINITION

A witness can be anyone who is at least 18 years of age and is not a beneficiary.

Please note: It is important that you keep an up-to-date and valid will.

PROTECTING YOUR PRIVACY

The personal information you are requested to provide is required in order to establish and maintain your membership in the APS Rollover and Allocated Pension Fund.

The Trustee is fully committed to comply with the National Privacy Principles in the way in which your personal information is stored and used. Full details of how this is achieved are contained in the Trustee's Privacy Policy, which is available from Member Services or on the Funds website at www.chifley.com.

Where to send this form/enquiries

APS Rollover and Allocated Pension Fund
PO Box N180
Grosvenor Place NSW 1220
website: www.chifley.com

Phone: 1800 800 002 (toll free)
(8.30 am – 5.00 pm Mon – Fri)
Fax (02) 9279 4130

