PRINTING INDUSTRY PENSION FUND

FOR S.A.T.U. MEMBERS

Principal Officer PO Box 12722 The Tramshed Pretoria 0126



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transfin@transfin.co.za

JOINING THE FUND

SATU Number		Т	T					П												-	Reg	ion											\Box	Т		
Member Surname		\top		П	П														Ť											lr	nitia	ıls	T			
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Gender M = MALE F = FEMALE																																				
Date of first contribution	า		С	С	Υ	′ \	/ 1	M	VI	D	D																									
Annual Remuneration		[R						,						(Att	tach	n pro	oof))				•													
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IMPORTANT NOTES																																				
Proof of the following documents MUST be attached to this document: ID document or									Passport Marriage Certificate																											
To the best of your kno or condition where the possible death or disab	sign ility	s or claii	syr	mpt	tom	is o	f the	at il	Ines																										γ	N
If Yes, complete Annex	ure A	1																																		
SIGNATURE: MEMBI	ER																						SIG	ΝA	TL	JRE	: R	EG	ION	IAL	. SE	CR	ETA	\RY	,	
DATE:		—	—	—																		_	DΔ	TF·												

ANNEX	URE A								
NAME:	MEMBE	R NUMBER:							
Importa	Important questions that must be answered by the member and information which must be conveyed to the member:								
QUESTI	ONS:								
1.	When did the pre-existing condition first occur?								
2.	What is the pre-existing condition?								
3.	Could you please give us permission to contact the medical practitioner/s for m	ore information if necessary?							
4.	Who is the doctor who first diagnosed the pre-existing condition? Please prov	vide his contact details.							
	Name:Te	el:							
5.	Please provide the contact details of the doctor who is currently treating you fo	r the pre-existing condition.							
IMI	PORTANT INFORMATION:								
	The member will be covered for all events other than the pre-existing condit (Except if the Fund's medical advisor determines otherwise.) Please note that failure to disclose any pre-existing condition could disqualify you								
AC ⁻	TIONS BY THE ADMINISTRATOR UPON RECEIPT OF APPLICATION:								
1.	The Administrator will contact the medical advisor to give his opinion as to who disclosed would affect the risk to the Fund for a one year period after joining.	at effect the pre-existing condition that was							
SIGNAT	URE: SATU OFFICIAL/CLERK	SIGNATURE: MEMBER							

DATE:

DATE: