



**Agri and Affiliated
Sectors Provident Fund**

Website: www.aspf.co.za
Principal Officer & Information Officer: Mr Lourie Bosman
Email address: agrisectorfund@verso.co.za

EMPLOYER PARTICIPATION APPLICATION

THIS FORM IS TO BE SUBMITTED 2 MONTHS PRIOR TO THE FIRST PREMIUM BEING DUE

FUND DETAILS

PARTICIPATING EMPLOYER NAME: _____
(to appear on rules and other Fund documentation)

COMMENCEMENT DATE: _____
(For Rate Review Purposes)

ACCREDITED CONSULTANT'S DETAILS

FIRST NAME: _____ SURNAME: _____

COMPANY NAME: _____

TELEPHONE NO.: _____

E-MAIL ADDRESS: _____

EMPLOYER DETAILS

COMPANY

REGISTERED NAME: _____

REGISTRATION/PRACTICE/TRUST DEED NUMBER: _____

TYPE OF BUSINESS: _____

REGISTERED PHYSICAL ADDRESS: _____

POSTAL ADDRESS: _____

TELEPHONE NO.: _____

PAYE NO.:

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CONTACT PERSON

FIRST NAME: _____ SURNAME: _____

TITLE (Mr/Mrs/Ms): _____ LANGUAGE PREF: _____

TELEPHONE NO.: _____

E-MAIL ADDRESS: _____

BANKING DETAILS

ACCOUNT NAME: _____

BANK NAME: _____

BRANCH NAME: _____ BRANCH CODE: _____

TYPE OF ACCOUNT: _____ ACCOUNT NUMBER: _____

ELIGIBILITY & CATEGORIES

ELIGIBILITY

Define the conditions for eligibility to membership:

A person in the full-time, permanent service of the PARTICIPATING EMPLOYER in respect of whom the PARTICIPATING EMPLOYER has notified the FUND as such in writing, who qualifies for membership in terms of the service provisions of the PARTICIPATING EMPLOYER and who is not in receipt of benefits that are payable in accordance with the provisions of the RULES;

MEMBER:

An EMPLOYEE who has been admitted to membership of the FUND in terms of the RULES and who has not ceased to be a MEMBER in terms of the RULES, including:

- (i) a DEFERRED RETIREMENT MEMBER,
- (ii) a PAID-UP MEMBER,
- (iii) an EMPLOYEE temporarily absent from the service of his or her EMPLOYER

PLANS, FEES AND PREMIUMS

Members may choose any of the following plans and will pay contributions accordingly to the fund. **The employer is to indicate on the member take-on schedule which plan the member will belong too.**

PLAN	A1	A2	B	C2	D	E
CONTRIBUTION	R 190.00	R 190.00	R 213.00	R 239.00	R 286.00	R 479.00

DEATH COVER	Cover	-	R 16 000	R 20 000	R 23 000	R 29 000	R 40 000
	Premium		R 18.60	R 22.60	R 26.57	R 33.21	R 46.49
ACCIDENT DEATH COVER	Cover	-	R 16 000	R 20 000	R 23 000	R 29 000	R 40 000
	Premium		R 5.07	R 6.16	R 7.25	R 9.06	R 12.67
CAPITAL DISABILITY COVER	Cover	-	-	-	-	R 29 000	R 40 000
	Premium		-	-	-	R 10.87	R 15.23
FUNERAL COVER	Cover	-	R 14 000	R 18 000	R 22 000	R 23 000	R 34 000
	Premium		R 27.53	R 36.75	R 43.63	R 45.89	R 68.83
PAID UP FUNERAL POLICY	Cover	-	-	-	-	-	-
	Premium		-	-	-	-	-
ADMINISTRATION COSTS	Fee	R 19.65	R 19.65	R 19.65	R 19.65	R 19.65	R 19.65
MARKETING COSTS	Fee	R 2.00	R 2.00	R 2.00	R 2.00	R 2.00	R 2.00
COMMUNICATION COSTS	Fee	R 2.10	R 2.10	R 2.10	R 2.10	R 2.10	R 2.10
INDEPENDENT ADVISOR FEE	Fee *	R 10.93	R 10.93	R 12.25	R 13.74	R 16.45	R 27.54
LESS TOTAL COST		R 34.68	R 85.88	R 101.51	R 114.94	R 139.23	R 194.51

NET CONTRIBUTION TOWARDS SAVING	R 155.32	R 104.12	R 111.49	R 124.06	R 146.78	R 284.49
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Members earning **R7 500 and more per month** may choose any of the following plans and will pay contributions accordingly to the fund. **The employer is to indicate on the member take-on schedule which plan the member will belong too.**

PLAN	SAL 1	SAL 2	SAL 3	SAL 4
CONTRIBUTION	R 635.00	R 951.00	R 1 271.00	R3 176.00

DEATH COVER	Cover	R 115 000	R 172 000	R 230 000	R 575 000
	Premium	R 68.88	R 103.64	R 137.55	R 344.40
ACCIDENT DEATH COVER	Cover	R 57 000	R 86 000	R 115 000	R 287 000
	Premium	R 8.40	R 12.71	R 16.91	R 42.26
CAPITAL DISABILITY COVER	Cover	R 115 000	R 172 000	R 230 000	R 575 000
	Premium	R 35.07	R 52.50	R 70.04	R 175.35
FUNERAL COVER	Cover	R 40 000	R 40 000	R 40 000	R 40 000
	Premium	R 54.08	R 54.08	R 54.08	R 54.08
ADMINISTRATION COSTS	Fee	R 19.65	R 19.65	R 19.65	R 19.65
MARKETING COSTS	Fee	R 2.00	R 2.00	R 2.00	R 2.00
COMMUNICATION COSTS	Fee	R 2.10	R 2.10	R 2.10	R 2.10
INDEPENDENT ADVISOR FEE	Fee *	R 36.51	R 54.68	R 73.08	R 150.00
LESS TOTAL COST		R 226.69	R 301.36	R 375.41	R 789.84

NET CONTRIBUTION TOWARDS SAVING	R 408.31	R 649.64	R 895.59	R 2 386.16
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METHOD OF PAYMENT

PAYMENT OF MONTHLY PREMIUMS

☐ EFT

☐ DEBIT ORDER

DECLARATION (DEBIT ORDER)

I _____ (FULL NAME), the mandated representative, hereby authorized Agri and Affiliated Sectors Provident Fund and Verso Benefits Administrator (Pty) Ltd as the Fund administrator to debit the monthly contributions against the bank account confirmed under the company details according to the debit order systems operated in co-operation with our bank and to debit our account accordingly with such amounts, as if every transaction has been undersigned by me. This authorization is valid for all amounts due in terms of the application form. I undertake to inform the Fund of any change in our bank particulars as set out above. If the bank claims any amount against the Fund in terms of this application form, I undertake to reimburse the Fund, including the interest as stated in Section 13A of the Pension Funds Act.

SIGNATURE: _____ DATE: _____

☐ I herewith authorize the Fund to debit the monthly contributions against our account according to the debit order system operated in co-operation with our bank and to debit our account accordingly with the agreed amounts in terms of the application form, as if every transaction has been undersigned by myself.

☐ I agree that I have read and understand the aforementioned information supplied by me is correct and true to my knowledge.

INVESTMENT MANDATE

INVESTMENT OPTION : SANLAM STABLE BONUS

AUTHORISATION OF MANDATE BY EMPLOYER

I _____ (FULL NAME) hereby confirm that:

- That the investment and portfolio options were explained to me by my consultant.
- The Trustees of the Fund and/or our consultant may act on our behalf regarding the execution of our investment options.

SIGNATURE: _____

DATE: _____

ADDITIONAL INFORMATION/DOCUMENTATION

Please provide the following information / documentation in electronic format:-

MEMBER DETAILS

- Employee Number*
- Category* (please indicate the PLAN which the member has elected for contribution)
- First Names*
- Surname*
- Gender*
- Date of Birth*
- ID Number
- Marital Status*
- Date Joined Employer*
- Date Joined Fund*
- Tax Number
- Street Address
- Postal Address
- Phone
- Email
- Language Preference (If this information is not supplied, the system will default to ENGLISH)
- Annual Pensionable Salary*

* Please note that this information is required in order to load a member.

SECTION 14 TRANSFERS

The Administrator require the following information to evaluate the current position.

PRE-TRANSFER

Are there any Section 14 transfers in progress pre-transfer? ☐ YES ☐ NO

If so, please provide the following information / documentation:-

- In the case of Section 14 Applications, pending FSCA Approval, copies of all FSCA correspondence.

POST-TRANSFER

Does the transfer involve a Section 14 application? ☐ YES ☐ NO

If so, please provide the following information / documentation:-

NAME OF EXISTING FUND _____

ATTACHMENTS

Please provide copies of the following:-

- Letter of Appointment
- Consulting Service Level Agreement

AUTHORISATION

EMPLOYER

I _____ (FULL NAME) hereby confirm that:

- I have the authority to sign the document on behalf of the participating employer/Manco.
- We have read, understood and accept the 'Terms and Conditions' and 'Administration Service Standard' as set out in this tender document.
- The information provided in this form is to the best of my knowledge correct.
- Verso Benefits Administrator (Pty) Ltd will not be held liable for any losses or damages due to acting on incorrect information provided in or together with this form.
- If this form has not been completed in its entirety and all relevant supporting documents has not been provided, Verso Benefits Administrator (Pty) Ltd reserves the right to re-negotiate the effective implementation date.
- If the information on this form differs to the signed tender, Verso Benefits Administrator (Pty) Ltd reserves the right to re-evaluate the administration fees quoted.
- I am aware that this form is not a legal document and Verso Benefits Administrator (Pty) Ltd will only be responsible for the Fund's administration once the relevant information has been provided to enable Verso Benefits Administrator (Pty) Ltd to effectively implement and administer the fund.

COMPANY NAME: _____

SIGNATURE: _____ DATE: _____

DESIGNATION: _____

EMPLOYER STAMP:

CONSULTANT

I _____ (FULL NAME) hereby confirm that:

- The information provided in this form is to the best of my knowledge correct.
- Verso Benefits Administrator (Pty) Ltd will not be held liable for any losses or damages due to acting on incorrect information provided in or together with this form.
- If this form has not been completed in its entirety and all relevant supporting documents has not been provided, Verso Benefits Administrator (Pty) Ltd reserves the right to re-negotiate the effective implementation date.
- If the information on this form differs to the signed tender, Verso Benefits Administrator (Pty) Ltd reserves the right to re-evaluate the administration fees quoted.
- I am aware that this form is not a legal document and Verso Benefits Administrator (Pty) Ltd will only be responsible for the Fund's administration once the relevant information has been provided to enable Verso Benefits Administrator (Pty) Ltd to effectively implement and administer the fund.

COMPANY NAME: _____

SIGNATURE: _____ DATE: _____

ANNEXURE 1: AUTHORISED SIGNATORIES

The following persons are authorised to sign on behalf of the company. Please ensure that a primary signatory is provided as well as a back-up signatory in the event of the primary signatory not being available.

AUTHORISED SIGNATORY I

NAME OF EMPLOYER/PAYPOINT _____

SURNAME _____ FIRST NAMES _____

TELEPHONE NO. _____ FAX NO. _____

EMAIL ADDRESS _____

SPECIMEN SIGNATURE _____ DESIGNATION _____

AUTHORISED SIGNATORY II

NAME OF EMPLOYER/PAYPOINT _____

SURNAME _____ FIRST NAMES _____

TELEPHONE NO. _____ FAX NO. _____

EMAIL ADDRESS _____

SPECIMEN SIGNATURE _____ DESIGNATION _____

AUTHORISED SIGNATORY III

NAME OF EMPLOYER/PAYPOINT _____

SURNAME _____ FIRST NAMES _____

TELEPHONE NO. _____ FAX NO. _____

EMAIL ADDRESS _____

SPECIMEN SIGNATURE _____ DESIGNATION _____

AUTHORISATION

I _____ (FULL NAME) hereby confirm that:

- As soon as we are aware of a change in signatory (ies), we will notify Verso Benefits Administrator (Pty) Ltd by completing and submitting this form.
- This is the latest form and it replaces / supercedes any other list of authorized signatories that has been provided to Verso Benefits Administrator (Pty) Ltd in the past.
- The Employer accepts full responsibility for the accuracy and integrity of all instructions to Verso Benefits Administrator (Pty) Ltd.
- Certified copies of the Identity Documents of the abovementioned individuals are required for purposes of compliance with the requirement of the Financial Intelligence Centre Act of 2001, and have been attached.

SIGNATURE: _____

DATE: _____

DESIGNATION: _____

COMPANY STAMP:

ANNEXURE 2: PERSONAL LIABILITY FOR NON-PAYMENT OF CONTRIBUTIONS

Contravention of Section 13A (payment of contributions to the fund) of the Pension Funds Act 24 of 1956 (the "Act") is a criminal offence and every director of a Company or every member of a Close Corporation or any person who is regularly involved in the management of the Company's or Close Corporation's overall financial affairs, or all the persons comprising the governing body of the employer, as the case may be, are personally liable for compliance with this section.

In terms of Section 13A(9)(a) of the Act the fund must request the employer to identify a "responsible person" that will be personally liable in the event of non-compliance with Section 13A.

If the employer should fail to comply with the nomination of a "responsible person", then all directors of the Company or all the members of a Close Corporation or any person regularly involved in the management of the Company or Close Corporation, or all the persons comprising the governing body of the employer, as the case may be, will be personally liable for non-compliance.

The following person is hereby identified by the employer as the "responsible person" with regard to the compliance with Section 13A of the Act in respect of the payment of contributions to the Fund.

RESPONSIBLE PERSON

NAME OF FUND _____

NAME OF EMPLOYER _____

SURNAME _____ FIRST NAMES _____

DATE OF BIRTH _____ ID NUMBER _____

DESIGNATION _____

TELEPHONE NO. _____ FAX NO. _____

EMAIL ADDRESS _____

ATTACHMENTS

Please attach a certified copy of the "responsible person's" ID document.

AUTHORISATION

I _____ (FULL NAME) hereby confirm that:

- The Employer has nominated the abovementioned to act as the "responsible person" in terms of section 13(A)(9)(a) of the Act and he/she has duly accepted his/her appointment and understands his/her responsibilities.
- As soon as we are aware of a change in the "responsible person", we will notify Verso Benefits Administrator (Pty) Ltd by completing and submitting a revised form.
- This is the latest form, which replaces / supercedes any other "responsible person" notification that has been provided to the Fund in the past.
- The Employer accepts full responsibility for the accuracy and integrity of all instructions and information provided to Verso Benefits Administrator (Pty) Ltd.

SIGNATURE: _____

DATE: _____

DESIGNATION: _____

EMPLOYER STAMP: