



The Growth Plan for Action for Blind People

Employee Application Form

MEMBERSHIP NUMBER To be completed by The Pensions Trust: M <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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EMPLOYEES ARE REQUIRED TO FULLY COMPLETE SECTIONS 1 – 3 AND SIGN THE DECLARATION

1. Your details

Title: Mr Mrs Miss Ms other (please state): _____ Male Female

Surname: _____ Forename(s): _____

Address: _____

_____ Postcode: _____

Telephone Number: _____ Email: _____

Date of Birth: ____/____/____

Status: single married widow(er) divorced civil partner

National Insurance Number:

Please advise The Pensions Trust of any future changes of address or status.

2. Previous pension arrangements

Have you ever previously been a member of The Pensions Trust? Yes No

If yes, please give membership number, if known: M

and the name of the employer: _____

The Growth Plan for Action for Blind People

3. Death Benefits and/or Dependants' Pensions

Note: The cost of providing death benefits and/or dependants' pensions is paid for by your employer.

Death Benefits – before retirement (Lump Sum)

A return of your personal fund is payable on death and four times your annual salary.

Dependants' Pensions

A benefit of 30% of your annual salary is payable as an annual pension to your dependants.

The Pensions Trust will contact you shortly for details of your nominated beneficiaries.

EMPLOYEE'S DECLARATION

I hereby apply to become a member of Growth Plan for Action for Blind People with The Pensions Trust and I agree to be bound by the terms and conditions of the Growth Plan (GP) as set out in the Trust Deed and Rules. I confirm that I have read the Growth Plan Guide for Members.

I consent to the processing of the data included in this form and any further personal information supplied by me or my employer.

I authorise my employer to deduct the agreed pension contributions from my salary (if appropriate).

Signed: _____ **Date:** ____/____/____

Full Name: _____

In order that we can send you a pension forecast that includes information about your State Pension, we need to get some information about you from the Department for Work and Pensions (DWP). To get that information we need to disclose your personal details to the DWP.

The information we get from the DWP will be used only for the purposes of providing you with a forecast of your pension rights.

If you do not wish us to contact the DWP for this information, please tick this box
As a result of this, the pension forecast you receive from us will not include State Pension information.

For further information on the above, please refer to our website www.thepensiontrust.org.uk

EMPLOYERS ARE REQUIRED TO FULLY COMPLETE THIS PAGE

4. Employer details

Name of Organisation: **Action for Blind People**

Employer Reference Number: **E I 0 7 7 8**

Normal Retirement Age: _____

Employer Contribution Rate: _____%

Employee Contribution Rate: _____%

Date employee joined employment: ____/____/____

Payroll Number: _____

Contractual hours per week: _____

Standard Full-time Hours: _____

Date of joining the Plan: ____/____/____

Annual Pensionable Salary: £ _____ pa

Declaration for late entrants

This declaration is in respect of an employee applying to join the Plan later than one year from becoming eligible to do so (Trust Deed and Rules: Common Rule 3.4 applies).

Has the employee completed three months' continuous service without absence through illness or injury immediately prior to the date they wish to join the plan? Yes No

If **No**, please give details of the period(s) of absence and the reason. (Please use an additional sheet if required).

Date(s) of absence

Reason for absence

_____ to _____

_____ to _____

If the member has not completed three months' continuous service, the enrolment may be postponed until this criterion has been met. Should this be the case, you will be contacted by The Pensions Trust.

EMPLOYER'S DECLARATION

I certify that the applicant is an employee of our organisation and I agree to ensure that contributions are paid to The Pensions Trust on behalf of this employee.

I understand contributions must be received by The Pensions Trust within legal time limits and must not be deducted before I receive confirmation that the employee has been enrolled.

Signed: _____ Date: ____/____/____

Full Name: _____

Position: _____

Email: _____

The completed form should be sent to the Growth Plan for Action for Blind People at the address below. Any queries please call 0113 394 2736 or email enquiries@thepensiontrust.org.uk



The Pensions Trust

