

Change in Contribution Rate Form

Defined Contribution (DC) Structure

PLEASE COMPLETE SECTIONS 1 & 2 AND SIGN THE DECLARATION THEN PASS THE FORM TO YOUR EMPLOYER TO SIGN THEIR DECLARATION.

1. Your details

Full Name: _____

Membership Number: M

Address: _____

Postcode: _____

Telephone Number: _____ Email: _____

2. Change in contribution rate (tick one box only)

I would like the change to be effective from 01/____/____.

Please note: This must be the 1st of the month. Your employer will confirm if this is possible.

I wish to **increase** my contribution to The CARE Scheme DC structure as follows (see also Note 1):

Contribution Type	Current Rate Paid	New Rate Paid
Additional Voluntary Contribution (AVC)	%	%

Note 1: Your normal contribution is your age divided by 10, minus 1, e.g. if you are 39 years old, your normal contribution would be $(39/10) - 1 = 2.9\%$. You may choose to pay a higher contribution rate. The rate above your normal contribution rate will be classed as an Additional Voluntary Contribution (AVC).

I wish to **reduce** my contribution to The CARE Scheme DC structure as follows:

Contribution Type	Current Rate Paid	New Rate Paid
Additional Voluntary Contribution (AVC)	%	%

The CARE Scheme

If you wish to amend your selected retirement date (SRD) or investment option, please complete the 'Switch Instruction Form', which is available to download from our website.

Please note: Any AVCs paid must be invested in the same fund and allocation as your regular contributions.

EMPLOYEE'S DECLARATION

I confirm I wish to make the change detailed above to the pension contributions I pay to The CARE Scheme. I authorise deduction from my pay at the rate stated overleaf.

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

Full Name: _____

EMPLOYER'S DECLARATION

I acknowledge the application from the member to change the contributions they pay into The CARE Scheme (tick below):

As a result of the change in the member's contribution, the employee's TOTAL contribution will change to ____%.

I have advised payroll to make the appropriate changes to contributions from the effective date indicated in Section 2.

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

Full Name: _____

Position: _____

Employer Number: E

Employer Name: _____

The completed form should be sent to The CARE Scheme at the address below. Any queries please call 0113 394 2553 or email enquiries@thepensiontrust.org.uk



The Pensions Trust