



APPLICATION FOR WITHDRAWAL/RETRENCHMENT BENEFIT

Corresponding language preference	English		Afrikaans	
(For office use only)	Claim Type	Fund	Region	Fund Number
				Council Number

Final contributions: _____ WKS @ R _____ From: _____ To Dated: _____.

_____ WKS @ R _____ From: _____ To Dated: _____.

Contributions received to last day of employment: YES NO .

Additional information: _____

MEMBER INFORMATION – Member to complete.

Member’s surname: _____

Full names: _____

Identity Number: _____ Date of birth: _____

A copy MUST BE attached to the application

Leaving date: _____

Last salary / wages: per week / month / annual R_____

Reason for application: _____

EMPLOYMENT HISTORY

Employed from _____ to _____ Company: _____

Employed from _____ to _____ Company: _____

Are you currently employed [Put a X in the correct box]	YES	NO
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If yes, give the name of the Company: _____

MEMBER MUST GIVE A PHYSICAL ADDRESS: _____

_____ Postal code: _____

MEMBER’S POSTAL ADDRESS: _____

_____ Postal code: _____

Contact tel number [Member or Relative] _____

MEMBER’S TAX DETAILS – to be completed by the EMPLOYER / MEMBER

Member’s Income Tax Number: _____

State name of Receiver where last forms was returned: _____

Note: A dispute with the Receiver of Revenue can delay the final payment of the claim.

MEMBER'S BANKING DETAILS – This must be completed by the Member's BANKERS, Please note benefits will only be paid into your [members] own account.

Account holder name: _____

Name of Bank: _____

Branch Code: _____

Account Number: _____

Type of Account: _____

Date: _____

BANK STAMP

I, the undersigned, hereby certify that the given information is correct in all aspects. I hereby authorize the fund to deduct from any benefits due to me, an amount which equates to the prescribed MIMED Contributions in respect of the period during which I received benefits from MIMED, subsequent to the termination of my employment in the Motor Industry, and the consequential termination of my membership of MIMED.

Member's Signature: _____ Date: _____

PLEASE NOTE THE FOLLOWING DOCUMENTATION ARE REQUIRED WITH APPLICATION

Copy of Member's Identity Document	
Certified copy of retrenchment Letter – if applicable On Company letterhead	
Recognition of Transfer – if Applicable	

PLEASE SEND COMPLETED DOCUMENTATION TO ONE OF THE FOLLOWING REGIONAL OFFICES

REGION	CONTACT NUMBER
MIBCO Eastern Cape PO BOX 7270 PORT ELIZABETH 6055	[041] 3640250
MIBCO Natal P O Box 17263 CONGELLA 4013	[031] 2055465
MIBCO Free State OFS PO BOX 910 BLOEMFONTEIN 9300	[051] 4094000
MIBCO SSC PO BOX 2578 RANDBURG 2125	[011] 3697500
MIBCO Western Province PO BOX 17 BELLVILLE 7535	[021] 9486400/05

