



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



