

The Medical & Associated Professions Superannuation Fund

Employer Payment Authority

This form is to be completed by an Authorised Officer of the Employer. Please use BLOCK LETTERS and a BLACK or BLUE pen. Write X in the appropriate boxes.

1 EMPLOYER DETAILS

Employer Number

Employer Name

2 MEMBER DETAILS

Member Number

Title Surname

Given Name(s)

Address

City/Suburb

State

Postcode

Date of Birth (DD-MM-YYYY)

Date Joined Company (DD-MM-YYYY)

3 PAYMENT DETAILS

Date (DD-MM-YYYY)

CESSATION

The above member ceased employment on: for the following reason:

Resignation

Retirement

Serious Ill Health

Other

If 'Other', please provide details below:

OR

TRANSFER

The above member has not ceased employment and we authorise you to transfer that member's benefit to the superannuation fund advised by the member. Future contributions will be paid to the member's new superannuation fund.

4 CONTRIBUTIONS TO EXIT DATE

Have all contributions been remitted for this member? Yes

Date (DD-MM-YYYY)

No

Final contribution will be remitted on:

5 SIGNATURE

Name of Authorised Officer

Job/Title Position

Email Address of Authorised Officer

Telephone

Authorised Signature

Date (DD-MM-YYYY)