RESET

AMP KiwiSaver Scheme

Life-shortening congenital conditions

Please send this completed form and supporting documents to:

Email: kiwisaver@amp.co.nz or

AMP KiwiSaver Scheme
Freepost 170, PO Box 55
Shortland Street, Auckland 1140

Please call us on 0800 267 5494 if you have any queries

Use this form to apply for an early withdrawal of your KiwiSaver savings in the case of Life-shortening congenital conditions.

Life-shortening congenital conditions means the member suffers from a condition that is congenital (i.e. exists from the date of their birth) and is either -

(a) a listed condition (one of the conditions specified by law); or

(b) a non-listed condition (one for which the member has medical evidence to verify that the condition is expected to reduce life expectancy below age 65).

Currently there are no listed conditions so all members will need to apply under option (b).

We can't process your request if you haven't provided verification of your identity, so please make sure you complete sections (g) and (h).

If you withdraw all your savings, we will close your AMP KiwiSaver Scheme account.

This form can be completed on-screen by typing content directly into the PDF document. Please use block letters if you're not completing this form online.

Once you have completed and signed this form please send it and any supporting documents to the address above.

A disclosure statement is available from your Adviser, on request and free of charge.

*These fields must be completed

(a) Your personal details

*Member number

K

Title

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other

*Date of birth

D D M M Y Y Y Y

*First names

*Surname

*IRD number

*Email

*Residential address

Postcode

*Postal address

Postcode

*Please provide at least one contact number

Home phone ( )

Work phone ( )

Mobile phone ( )

Prescribed Investor Rate (PIR)

☐ 10.5% ☐ 17.5% ☐ 28%

PIE tax is deducted from any withdrawals using the information held by AMP at the time a withdrawal is made. If your PIR details have changed, please advise your new PIR. To help determine your PIR, go to **amp.co.nz/PIE** or **ird.govt.nz**. If a PIR is not selected and has not been previously selected, or you supply an incorrect IRD number, the default rate of 28% will apply. Inland Revenue may also instruct AMP to apply a different PIR.

(b) Withdrawal details

*I request (please tick)

☐ The full value of my AMP KiwiSaver Scheme account *(after deduction of any fees, expenses, taxes);*

OR

☐ a partial withdrawal of $

If you've requested a partial withdrawal above, and you're invested in more than one investment fund, please tell us below which funds to withdraw from. If you don't tell us the funds and amounts, we will split the withdrawal equally across your funds.

Investment fund(s)	Amount ($)

Investment fund(s)	Amount ($)

*Have you received financial advice from an Adviser in making this decision to apply for a withdrawal? Yes ☐ No ☐

If yes, please ensure your Adviser completes section (j) at the end of this form.

(c) Payment instructions

Please provide proof of your nominated bank account in the form of an **original pre-encoded bank deposit slip** or a certified true copy of a bank statement. The bank account must be a NZ bank account in your name or be a joint account incorporating your name.

*Account name (account held in my name or jointly held in my name)

*Account number

(d) Statutory declaration

*I (full name of member)

*of (Address)

Occupation

solemnly and sincerely declare that all the information provided in or with this application is true and correct and that:

1. I am suffering from a life-shortening congenital condition as defined on page 1 of this form, and I am applying to The New Zealand Guardian Trust Company Limited as Supervisor of the AMP KiwiSaver Scheme ('Supervisor') for a withdrawal from my AMP KiwiSaver Scheme account.
2. The information in this application (and any attachments) is true and correct.
3. I understand that acceptance of the application is at the discretion of the Supervisor and that fees may apply.
4. I understand that AMP and/or the Supervisor may request additional information from me relating to this application.
5. New Zealand has not been my principal place of residence for the following periods:

   From D D M M Y Y Y Y to D D M M Y Y Y Y

   From D D M M Y Y Y Y to D D M M Y Y Y Y

   I confirm that for all other periods my principal place of residence was New Zealand.

   I understand that any Government contributions claimed for any period(s) that New Zealand was not my principal place of residence, will be returned to Inland Revenue.

6. I acknowledge that I have rights of access to, and correction of, the information held by AMP or the Supervisor of the AMP KiwiSaver Scheme subject to the provisions of the Privacy Act 1993 and amending legislation. I understand that the information supplied by me with this application and any other information provided in connection with my membership or my account, either by me, my employer, the Inland Revenue or any other party, will be used by AMP and the Administration Manager and/or any parties related to them to verify my identity, process this application and to administer my membership, and to operate, the AMP KiwiSaver Scheme and may be disclosed for these purposes to other parties where relevant, including the Supervisor, the Financial Markets Authority, the Inland Revenue, my employer, an adviser or other intermediary or to any other party as required. I also understand that these parties may share and disclose information to each other and any other parties for the purpose of administering my membership, and to operate, the AMP KiwiSaver Scheme. The information may also be used by AMP or third parties to offer me other products or services made available by the AMP group, and for market research purposes. I can access and if required correct my personal information by contacting AMP.

   I authorise AMP and/or the Supervisor to obtain additional information in relation to this Withdrawal Application from any third party/entity.
7. I understand that if this application is approved and a full withdrawal of my AMP KiwiSaver Scheme account is made, then my membership of the AMP KiwiSaver Scheme will end.
8. I understand that my funds will be released to me as if I have reached the New Zealand superannuation qualifying age (age 65 and above).
9. I understand that after a withdrawal of funds, I am no longer eligible to receive government contributions or compulsory employer contributions in relation to my future contributions, if any.
10. I confirm that I am not an undischarged bankruptee or incapable of managing my financial affairs and that I am properly entitled to any payment made pursuant to this application and that no other person has any claim against it.
11. I indemnify the Supervisor, AMP and any of their related companies against all claims, actions, demands, proceedings, costs or expenses, damages or liability arising and discharge them from any liability in respect of my membership of the AMP KiwiSaver Scheme and/or any withdrawal payment made.

I make this solemn declaration conscientiously believing the same to be true and by virtue of the Oaths and Declarations Act 1957.

*Declared at PLACE *this *(date)* D D M M Y Y Y Y

***Member's signature** SIGN HERE

Before me (Justice of the Peace, Solicitor, Notary Public, or other person authorised to take statutory declaration, such as the Registrar or Deputy Registrar of the High Court or of any District Court or a member of Parliament):

*Full name, title/office of person taking declaration

*of city *(where signing)*

*Occupation

***Signature of person authorised to take declaration** SIGN HERE

*Date D D M M Y Y Y Y

OFFICIAL MARK

Please also complete section (h) if applicable.

(e) Doctor's confirmation – please ask your Doctor to complete

*I, Dr (name)

*of (address)

*Please provide at least one contact number

Mobile phone ( )

Work phone ( )

*Email

certify that:

(i) I am a registered practitioner with the Medical Council of New Zealand

(ii) the person named in section (a) is a patient of mine; and

(iii) in my opinion, the above-named has (please tick):

☐ a listed life-shortening congenital condition

OR

☐ a non-listed life-shortening congenital condition (please state):

As the Doctor of the member outlined in section (a), please give a brief description of the patient's condition and describe in the space provided below:

(i) how the condition is a life-shortening condition(i.e. one that is expected to reduce life expectancy of the member to below age 65; and

(ii) confirm that the member suffers from the condition.

***Doctor's signature**

SIGN HERE

*Date

D D M M Y Y Y Y

(f) Supporting documentation

*Please supply the following supporting documentation with this application:

☐ Specialist(s) or medical practitioner's medical certificate providing specific details of your condition. For those with non-listed conditions, the medical certificate should outline the existing national or international research that forms the basis for the life expectancy assessment.

(g) Your identity documents

Proof of identity

Please complete one of the options listed below and attach copies of the requested document(s).

Please tick which document you are providing.

Option 1 ☐ ONE document from this section:

☐ NZ passport (identity page)	☐ NZ firearms licence
☐ Overseas passport (identity page)	☐ NZ certificate of identity

OR

Option 2 ☐ NZ driver licence **plus** ONE of the following:

- ☐ Super Gold card
- ☐ NZ citizenship certificate/Citizenship certificate issued by foreign government
- ☐ NZ full birth certificate/Birth certificate issued by foreign government
- ☐ Bank statement or IRD statement issued in your name in the last six months

OR

Option 3 ☐ 18+ identity card or Kiwi Access card **plus** ONE of the following:

- ☐ NZ full birth certificate/Birth certificate issued by foreign government
- ☐ NZ citizenship certificate/Citizenship certificate issued by foreign government

Proof of address

Please provide one of the documents below as proof of your **residential address**. The document must be **addressed to you**, and dated within the **last six months**.

- ☐ Letter or invoice from utility company (eg electricity, gas, phone, Sky TV)
- ☐ Bank statement
- ☐ Insurance policy or investment portfolio document
- ☐ Current rental tenancy agreement
- ☐ Letter from government agency (eg Inland Revenue, rates bill, vehicle registration)

IMPORTANT:

1. If you are providing previously certified identity documents, please ensure the documents have been certified not more than three months prior.
2. Please attach only certified copies of the original documents to this form.

(h) Certify your documents

Certifying within New Zealand

DECLARATION BY TRUSTED REFEREE, AMP EMPLOYEE OR ADVISER (CERTIFYING IN NEW ZEALAND)

I, FULL NAME OF TRUSTED REFEREE confirm that

1. I have sighted today the original of each document identified with a tick in section (d) above verifying the identity and address of the person named in section (b) of this form, and attached to this statement are true copies of those documents **initialled and dated** by me.
2. The documents that have been provided represent the identity of the person named in section (b) of this form.
3. I am a **(tick one of the following)**
   - ☐ New Zealand Lawyer
   - ☐ Justice of the Peace
   - ☐ Chartered Accountant
   - ☐ Police Constable
   - ☐ Registered Medical Doctor
   - ☐ Registered Teacher
   - ☐ Fellow of the New Zealand Institute of Legal Executives
   - ☐ Registrar or Deputy Registrar of the High Court or a District Court
   - ☐ AMP employee or Adviser (and AMP has authorised me to be its agent to conduct AML customer due diligence on its behalf)
4. I am not related to and do not live at the same address as the person named in section (b) of this form.

Signature of trusted referee, AMP employee or adviser

SIGN HERE

Dated

D D M M Y Y Y Y

Certifying outside of New Zealand

When certifying documents outside of New Zealand, your trusted referee must be a person who is authorised to take **statutory declarations** under the laws of the country, state or territory where the documents are being certified.

For more guidance please contact your Adviser or AMP.

DECLARATION BY TRUSTED REFEREE (OUTSIDE NEW ZEALAND)

I, FULL NAME OF TRUSTED REFEREE confirm that

1. I have sighted today the original of each document identified with a tick in section (d) above verifying the identity and address of the person named in section (b) of this form, and attached to this statement are true copies of those documents **initialled and dated** by me.
2. The documents that have been provided represent the identity of the person named in section (b) of this form.
3. I am a ROLE/DESIGNATION
4. In this capacity, I am authorised to take statutory declarations under the Laws of RELEVANT OVERSEAS JURSIDICTION
5. I am not related to and do not live at the same address as the person named in section (b) of this form.

Signature of trusted referee

SIGN HERE

Dated

D D M M Y Y Y Y

(i) Checklist and next steps

***Checklist:**

Please check you have completed the form correctly

- ☐ Have you completed all fields with an *?
- ☐ Have you completed the statutory declaration in Section (d)?
- ☐ Have you attached proof of your bank account in the form of an original pre-encoded bank deposit slip or a certified true copy of a bank statement?
- ☐ Has your doctor completed Section (e)?
- ☐ Have you attached documentation to support your application (eg specialist medical certificates and assessments)?
- ☐ Have you attached any necessary verification of identity and proof of address documents?
- ☐ If you are under 18 years of age, has your parent/s or guardian completed a separate `Acting on behalf of' identity verification form and attached documents required by that form?

Next steps:

- If the request is approved, we will process your withdrawal request within 8 working days. We will process your withdrawal at the unit prices effective on the day of your withdrawal. Any contributions received after the processing date will not be eligible for any further withdrawal under this application.
- If the request is approved, we will direct credit your account and send you a letter confirming the amount of your withdrawal.
- If your request is not approved, we will advise you.

(j) For Adviser use only

AMP Adviser name (if applicable)

B	L	O	C	K		L	E	T	T	E	R	S				

AMP Adviser number

FSPN *(please use your QFE's FSPN if you are a QFE Adviser)*

I confirm that I am a:

- ☐ AFA (entitled to sell Category 1 Product)
- ☐ AMP QFE Category 1 Adviser
- ☐ Other _____

And I certify that the information provided in this Adviser Information Section is correct and that I have complied with the requirements of the Financial Advisers Act 2008 and all other applicable laws.

Signature of Adviser

SIGN HERE

Date

D	D	M	M	Y	Y	Y	Y