

1. Personal details

Member number:

Title: Mr Mrs Miss Ms Other

Surname:

Given name/s:

Date of birth:

Address:

Suburb: State: Postcode:

Contact phone number: Mobile number:

Employer name:

Employer number: Payroll number:

2. Plan type

Defined Benefit Vision Super Saver City of Melbourne Parks ASU

3. Termination details - Reason for termination:

Resignation/dismissal Retirement Retrenchment Death Disability/ill health (please refer to Important Notice below)

Date of termination: **For Defined Benefit, City of Melbourne or Parks Victoria members:**

If transferring to another Defined Benefit employer please provide employer name and number (if known)

Employer name: Employer number:

IMPORTANT NOTICE: Members of Vision Super Saver and ASU plans wanting to apply for disability benefits should contact our Member Services team to request the appropriate application forms. If employee is a Defined Benefit, City of Melbourne or Parks Victoria Member and is wanting to apply for disability benefits, please use Form 4: Application for disability benefits.

Do not complete the following if termination advice is for a Vision Super Saver only member

Was this employee on leave without pay at date of termination? Yes No

Date employment commenced: Full time salary at date of termination:

Date salary took effect: Service fraction at termination date: Date service fraction took effect:

Contributions owed by member to employer and to be recovered by Vision Super:

(Do not include any contributions paid in advance of termination. These will be credited to your authority.)

4. Provide Super Saver contribution details

Date of last contribution: Remittance number: Employer's contribution: Member's contribution:

Are there any further contributions for this member? Yes No

If yes, please state amount and date payment will be made:

Date: Employer's contribution: Member's contribution:

IMPORTANT NOTICE: Please note that no benefit can be paid to the member until such time that this form is received by Vision Super and all outstanding contributions have been made. Outstanding contributions (both employer and employee) must be paid within 28 days of termination date.

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T E R

Please forward this completed form to: PO Box 18041, Collins Street East, Melbourne VIC 8003

Phone 03 9911 3222

Regionals 1300 300 820

Fax 03 9911 3299

www.visionsuper.com.au

Vision Super Pty Ltd ABN 50 082 924 561 AFSL 225054, is the Trustee of the Local Authorities Superannuation Fund ABN 24 496 637 884

5. Signature of authorised officer

Name of authorised officer: (please print)

Signature of authorised officer:

Date:

This information is required for the sole purpose of managing and payment of superannuation benefits and entitlements and will be protected in accordance with the provisions of the Privacy Act 1988 and Vision Super privacy policies.

6. Certification

This section should only be completed for Defined Benefit, City of Melbourne or Parks Victoria Plan members when termination is due to retrenchment.

I hereby certify that the employee named above has been retrenched for the purposes of the Trust Deed and understand that we will incur a 'retrenchment' increment for funding purposes.

City of Melbourne/Parks Victoria only:

I understand that a top up contribution will be charged for exits other than retrenchment.

Name of authorised officer or CEO: (please print)

Signature of authorised officer or CEO:

Date:

This information is required for the sole purpose of managing and payment of superannuation benefits and entitlements and will be protected in accordance with the provisions of the Privacy Act 1988 and Vision Super privacy policies.