



**EMPLOYER AUTHORIZED SIGNATORY  
(BENEFIT PAYMENTS)**



This form is required to ensure that we correctly identify those persons in your Organization who are authorized to sign Pension / Provident Fund documentation on behalf of the Employer.

|                       |  |
|-----------------------|--|
| <b>FUND NAME:</b>     |  |
| <b>EMPLOYER NAME:</b> |  |

**AUTHORIZED PERSON**

|                              |  |
|------------------------------|--|
| <b>SURNAME / INITIALS:</b>   |  |
| <b>FIRST NAME:</b>           |  |
| <b>EMPLOYER DESIGNATION:</b> |  |
| <b>SPECIMEN SIGNATURE:</b>   |  |

|  |                         |  |
|--|-------------------------|--|
| <b>Please state the number of signatories required</b> | <b>Number required:</b> |  |
|--|-------------------------|--|

**Note:** Please complete **ONE form per signatory** required.

On behalf of the Employer, as named above, we confirm that the following staff member is hereby authorized to sign benefit payment forms instructing the Fund's Administrators to pay benefits in terms of the Rules of the Fund.

|                             |                             |
|-----------------------------|-----------------------------|
|                             |                             |
| <b>AUTHORIZED SIGNATORY</b> | <b>EMPLOYER DESIGNATION</b> |

**FULL NAMES**

|                                |             |
|--------------------------------|-------------|
| <b>EMPLOYER REPRESENTATIVE</b> | <b>DATE</b> |
|                                |             |

THIS INSTRUCTION WILL REMAIN IN FORCE UNTIL ALTERED IN WRITING  
BY THE ABOVE EMPLOYER REPRESENTATIVE.

Please return this form by post or forward the information electronically to: [admin@fundwise.co.za](mailto:admin@fundwise.co.za)

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