

**FOUNDERS OF IMARA POST-RETIREMENT MEDICAL FUND**

CPF FINANCIAL SERVICES LIMITED
CPF House, 7th Floor, Haile Selassie Ave.
PO Box. 28938 - 00200, Nairobi, Kenya



KENBRIGHT HOLDINGS LIMITED

ACK Garden House, Ground Floor - Block D, 1st Ngong Ave.
PO Box. 28281 - 00200, Nairobi, Kenya

1. EMPLOYER DETAILS

Registered Name of Organization

Registered Address

2. COMMENCEMENT DATE

Commencement Date of Participation in the fund

3. BENEFITS DESIGN

Definition of an Eligible Member

☐

Permanent

☐

Contract

Vesting of Benefits

☐

100%

☐

Other

4. EMPLOYEE DATA

Number of Employees

Mode of Contribution

☐

Voluntary

☐

Payroll

5. POST RETIREMENT MEDICAL FUND CONTRIBUTIONS

Employer Contribution (%)

Employee Contribution (%)

If you wish to make Voluntary contributions, please tick the box

☐

If you have a different contribution structure for different employees, please complete the section below

Employer's Physical Address

6. RETIREMENT AGES

Normal Retirement (Years)

Early Retirement (Years)

Please confirm if Late Retirement will be permitted

YES

☐

NO

☐

7. TRANSFERS FROM OTHER RETIREMENT FUNDS

ITEM	DETAILS
Name of Transferor Fund	
Mandate of Transferor Fund	
Date of Transfer Commencement	
Contacts of Principal Contact	Email
	Telephone

8. INVESTMENTS

Choice of Investment Strategy

Insured Option

☐

Segregated Option

☐

Hybrid Option

Combo 1: 50% Segregated, 50% Insured

☐

Combo 2: 25% Segregated, 75% Insured

☐

9. MEMBERS OF MANAGEMENT COMMITTEE

Note: An Employer with his employees shall nominate not more than 3 representatives to form a management committee. The following people are authorized to sign the specified forms on behalf of the employer to act as liaison person(s) between the scheme and the trustees.

SIGNATORY 1

FIELD	DETAILS
Full Name(s) of Signatory	
Designation	
Contacts Details	Email Telephone
Benefits authorised to sign:	☐ Withdrawal ☐ Retirement ☐ Death ☐ Disability ☐ Immigration ☐ Other (specify) _____
Specimen Signature _____	

SIGNATORY 2

FIELD	DETAILS
Full Name(s) of Signatory	
Designation	
Contacts Details	Email Telephone
Benefits authorised to sign:	☐ Withdrawal ☐ Retirement ☐ Death ☐ Disability ☐ Immigration ☐ Other (specify) _____
Specimen Signature _____	

SIGNATORY 3

FIELD	DETAILS
Full Name(s) of Signatory	
Designation	
Contacts Details	Email Telephone
Benefits authorised to sign:	☐ Withdrawal ☐ Retirement ☐ Death ☐ Disability ☐ Immigration ☐ Other (specify) _____
Specimen Signature _____	

IMPORTANT NOTICE

As soon as you are aware of a change in signatories, please notify Imara Post Retirement Medical Fund by signing and forwarding this form to contact persons provided in the Administration Manual. It will replace any other list of signatories previous provided to the scheme

9. DECLARATION BY THE EMPLOYER

The conditions of participation are governed by the Trust Deed & General Rules of the Imara Post Retirement Medical Fund (These are available on request)

DECLARATION:

I _____

on behalf of the Employer as set out in Section A of this application, confirm that I am applying to the Imara Post Retirement Medical Fund, and:

- I. Confirm that the benefits selected will be in accordance with the applicable options, which will be selected in the Special Rules as agreed with the Trustees and the Participating Employer.
- II. I hereby warrant and confirm that I am duly authorized on behalf of the Participating Employer.
- III. I further understand that the Trust Deed and General Rules of the Imara Post Retirement Medical Fund shall govern the Scheme and this Application forms the basis of our participation.

SIGN-OFF SECTION

FIELD	DETAILS
Signed at	
On this Day	
Name	
Designation	
Witness Signature	
Employer Stamp	