BCF
Your Workplace Retirement Scheme

KiwiSaver
Poua he Oranga
KiwiSaver Act 2006

Application for Withdrawal – Serious Illness

Use this form to apply for a withdrawal from your KiwiSaver account if you are suffering serious illness. We will also require you to complete an AML Identity Verification form which is available by calling 0800 223 4636 or emailing bcfkiwisaver@mjw.co.nz

Section A Introduction

KiwiSaver is a long-term retirement savings initiative. Because it is specifically designed to help you to save for your retirement, there are only very limited circumstances in which you can withdraw funds prior to your qualifying date (the date when you reach New Zealand Superannuation age – currently 65 – or the date, if later, when you complete 5 years' KiwiSaver membership).

One of these circumstances is serious illness. Under the KiwiSaver Act 2006, serious illness means an injury, illness, or disability—

a) that results in the member being totally and permanently unable to engage in work for which he or she is suited by reason of experience, education, or training, or any combination of those things; or

b) that poses a serious and imminent risk of death.

As outlined above, the criteria for withdrawal on the grounds of Serious Illness are explicit and high. **If your inability to work is temporary then you are unlikely to qualify for a serious illness withdrawal** and may wish to consider applying for a withdrawal on the grounds of Significant Financial Hardship instead.

If the Trustee determines you are suffering serious illness, you can withdraw all or a part of your total KiwiSaver balance including the $1000 kick-start and the amount of the Crown's Member Tax Credit contributions.

To make an application you need to:

- Complete sections B, C, D and E.
- Ask your medical practitioner to complete section F.
- Attach a pre-printed deposit slip for the bank account you wish money to be paid into.
- Sign the form and have your signature witnessed by a Justice of the Peace, Solicitor, or other person authorised to take a statutory declaration.
- Return the completed form to:

BCF KiwiSaver Scheme, C/- MJW, PO Box 1096, Wellington 6140

If you have any questions about completing this form, please call 0800 BCF INFO (0800 223 4636).

Section B Your Personal Details

1. Your IRD Number ☐☐☐ ☐☐☐ ☐☐☐

2. Your Member Number ☐☐☐☐☐☐

3. Your name ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ________

First Name(s) ________ Surname ________

4. Your Postal Address

Street Address/ PO Box ________

____

Suburb or RD ________

Town or City ________

Postcode ☐☐☐☐

5. Date of birth ________

6. Occupation ________

7. Contact phone no ________

8. Email address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Section C Amount Requested

9. How much money do you need?

☐ *Amount* $ ________ . ____

☐ all available funds (after deduction of any fees, expenses and taxes). I understand my KiwiSaver account will then be closed.

Section C Amount Requested (continued)

Have you transferred money from a UK Pension Scheme after 5 April 2006?

☐ No ☐ Yes – please contact us for information. An extra withdrawal form is required.

10. If your application is approved, which bank account would you like payment to be made into?

Bank Account Name _____

Bank Account Number ☐☐ ☐☐☐☐ ☐☐☐☐☐☐☐ ☐☐☐

Section D Statement of your condition

11. Name of GP _____ 12. Years of attendance _____

13. Exact nature of your serious illness _____

_____

14. When did your serious illness commence ____/____/____ (date)

15. Doctor or specialist treating you _____

Address _____

16. Other comments that may assist the Trustee _____

_____

Section E Your declaration

I solemnly and sincerely declare that:

☐ I have had my principal residence in New Zealand for the entire period that I have been a member of KiwiSaver

☐ I was living overseas for the following dates

____/____/____ to ____/____/____ *[insert dates]*

and I understand I do not qualify to be paid the member tax credit for this period

I understand the Trustee, in deciding whether to pay this application:

- might require further information from me relating to this application;
- might need to seek and obtain information that is held by any other person or organisation that the Trustee considers appropriate for the purpose of checking the information in and to assist in assessing this application and I authorise any person holding information relevant to this application to disclose it to the Trustee on request; and
- will use and disclose the information about my serious illness for the sole purpose of assisting with the processing of this application.

I do solemnly and sincerely declare that the information provided in this application and the attached documents (if any) is complete and correct to the best of my knowledge and I make this solemn declaration conscientiously believing the same to be true and by virtue of the Oaths and Declarations Act 1957.

Signature _____
Your signature

Declared at _____ ____ day of _____ 20 ____
Location *Date*

Signature _____
Justice of the Peace, Solicitor, or other person authorised to take a statutory declaration

Declaration taker's details/stamp

Section F Your Doctor's declaration of your Serious Illness

Patient's name ______________________________

Postal address ______________________________

I, Dr. ______________________________

of ______________________________ ______________________________
Town or City

Contact Numbers ______________________________ ______________________________
Daytime Mobile

Email Address ______________________________

certify that:

- I am a medical practitioner registered with the Medical Council of New Zealand
- The above-named is a patient of mine and I gave him/her a full medical examination on ___/___/___ (date)
- In my opinion, the above-named has an injury, illness or disability which *(please tick appropriate box(es))*:

☐ results in them being totally and permanently unable to engage in work they are suited for because of experience, education or training, or any combination of these or;

☐ poses a serious and imminent risk of death.

I form this opinion based on (give a brief description of the patient's condition):

____

____

____

____

Records/reports attached ☐

Signature ______________________________ Date ___/___/___

Medical Practice Stamp

Checklist

I have ☐ completed Sections B, C & D, and

☐ signed and dated Section E - your statutory declaration, in the presence of a person authorised to take a statutory declaration

☐ had Section F completed by my Doctor

I attach ☐ a pre-printed bank deposit slip or bank statement showing the account name and number into which payment is requested to be made. Payments will only be made to a third party with the provision of additional information. Please contact us if a third party payment is required.

☐ supplementary information in support of this application, such as medical results and certificates

☐ a completed AML form

Please return the completed form and documentation to:
Post: BCF KiwiSaver Scheme, C/- MJW, PO Box 1096, Wellington 6140
Or Courier: BCF Kiwisaver, C/- Melville Jessup Weaver, Kiwi Wealth House, Level 7, 20 Ballance Street, Wellington 6011

If you have any questions about completing this form, please call 0800 BCF INFO (0800 223 4636).

The information in this form is being collected for the purposes of effectively managing your BCF KiwiSaver Scheme account and it will be held by MJW. It may be disclosed to third parties to the extent that is necessary to administer your application and any withdrawal from the BCF KiwiSaver Scheme. You can ask to see the personal information that MJW holds about you by calling us on 0800 223 4636.