

Withdrawal Form

SERIOUS ILLNESS

Your details

Title Given name(s) (please print) Surname

Postal address

Street number and name Suburb

Town/City Postcode Country

IRD no. Fisher Funds KiwiSaver Member Number

Home phone () Business phone () Mobile phone

Serious illness withdrawal request

Amount requested for withdrawal \$

* (This may be an amount up to the value of your KiwiSaver account – please call us on 0800 FFKIWI (0800 335 494) if you are unsure what this amount is).

As per the KiwiSaver Act we require the following proof that you are suffering a serious illness:

- Proof of permanent and total disablement or serious and imminent risk of death (certified medical report/certificate).

Payment details

Note: Fisher Funds will only make payments in New Zealand dollars to a New Zealand bank account.

Name of bank account

Bank Branch number Account number Suffix

Statutory declaration

I do solemnly and sincerely declare that:

1. I am a member of the Fisher Funds Growth KiwiSaver Scheme
2. I am suffering a serious illness
3. I am applying to the Trustee to withdraw my balance from the Fisher Funds Growth KiwiSaver Scheme
4. Details of my assets and liabilities have been accurately completed on the attached sheet.
5. I have lived in New Zealand since opening my KiwiSaver account, or (if otherwise) I have detailed below the periods for which I had my principal place of residence in New Zealand since opening my KiwiSaver account:

If you have lived overseas since opening your KiwiSaver account, please tell us the periods for which you had your principal place of residence in New Zealand since opening your KiwiSaver account:

Please note that the Trustee may request more information.

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

Signature of member

Date

/ /

Before me

Date

/ /

A justice of the peace, or solicitor, or notary public, or other person authorised to take a statutory declaration.

I certify that I have read the notes and that all information I have supplied is correct.

Send your completed form to Fisher Funds, c/o Trustees Executors, PO Box 409, Wellington, 6140



Withdrawal Form

SERIOUS ILLNESS

Doctor's declaration of serious illness

Patient

Title

Given name(s) (please print)

Surname

Postal address

Street number and name or PO Box

Suburb

Town/City

Postcode

Country

Doctor

I, Dr

of

Town or city

Daytime phone

Mobile phone

Email address

certify that:

- I am a registered medical practitioner with the Medical Council of New Zealand
- The above named is a patient of mine and I have recently given them a full medical examination
- In my opinion, the above named has an injury, illness or disability (delete options below that don't apply) which:
 - results in them being 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):

Signature

Date