NZ Funds KiwiSaver Scheme

Application for Withdrawal
Life-Shortening Congenital Condition

Use this form to apply for a retirement withdrawal from the NZ Funds KiwiSaver Scheme if you have a life-shortening congenital condition.

We will also require you to complete an identity verification form, AML Form for an Individual (Form 1), which is available on our website www.nzfunds.co.nz > KiwiSaver > Documents > Member Forms.

Return to NZ Funds KiwiSaver Scheme, Private Bag 92050, Victoria Street West, Auckland 1142, or by email to nzfkiwi@linkmarketservices.com.

1. Introduction

You can apply to withdraw from the NZ Funds KiwiSaver Scheme if you have a life-shortening congenital condition.

A life-shortening congenital condition:

a. is listed as a life-shortening congenital condition by the KiwiSaver regulations:
   - Down's syndrome
   - Cerebral palsy
   - Huntington's disease
   - Fetal alcohol spectrum disorder; **or**

b. exists for a person from the date of their birth and is likely to reduce the person's life expectancy below the New Zealand superannuation qualification age.

You can make a life-shortening congenital condition withdrawal at any time before age 65. For withdrawal on these grounds you do not need to retire, and you can either continue or return to paid employment after the withdrawal. However, you will be treated as having reached your retirement age.

This means that:

a. if you remain in (or later re-join) KiwiSaver, you can make further withdrawals, however

b. you are no longer entitled to either government or compulsory employer contributions in relation to any later member contributions.

If you withdraw the full amount of your KiwiSaver Scheme account, you will cease to be a KiwiSaver member. The Supervisor must approve your withdrawal application. To make an application you need to:

- complete sections 1, 2, 3 and 4;
- ask your medical practitioner to complete section 6;
- attach a pre-printed deposit slip for the bank account you wish the money to be paid into;
- sign the form in section 5 and have your signature witnessed by a Justice of the Peace, Solicitor, or other person authorised to take a statutory declaration; **and**
- return the completed form to NZ Funds KiwiSaver Scheme, Private Bag 92050, Victoria Street West, Auckland 1142, or by email to nzfkiwi@linkmarketservices.com.

If you have any questions about completing this form, please call us on 0800 NZF KIWI (0800 693 5494).

2. Your personal details

Member number

N Z F

IRD number

Name

Title | First name | Middle name(s) | Surname

Residential address (not PO Box)

Street

Suburb | Town / City | Postcode

Phone number(s)

Mobile | Home | Business

Email

If you supply an email address, we will send you information relating to your investment by electronic means.
We suggest using your personal rather than work email address as this is less likely to change over time.

3. Withdrawal request

I would like to make a (please tick):

☐ **Regular withdrawal (minimum $100)** Amount $ ☐ **Weekly*** ☐ **Fortnightly*** ☐ **Monthly***

☐ **Partial withdrawal (minimum $500)** Amount $

☐ **Full withdrawal of all available funds****

All partial withdrawals will be deducted proportionately across each Strategy you are invested in.

* Weekly and fortnightly withdrawals will be paid on a Tuesday. Monthly withdrawals will be paid on the 15th of each month or the prior working day if this falls on a weekend or public holiday.

** Please allow up to one month for this process to take place as we have to make a final Government contribution claim from Inland Revenue.

Any withdrawal payments will only be paid to a New Zealand bank account in your name (held individually or jointly).

Please attach a deposit slip or other confirmation of your bank account details.

Bank account name

Bank | Branch

Bank | Branch | Account | Suffix

4. Statement of your condition

Name of general practitioner

Years of attendance

Exact nature of your life-shortening congenital condition

- ☐ Down's syndrome
- ☐ Cerebral palsy
- ☐ Huntington's disease
- ☐ Fetal alcohol spectrum disorder

Particulars of condition if not listed above

Doctor/specialist treating you

Address of doctor/specialist

Street

Suburb | Town / City | Postcode

Other comments that may assist the supervisor

5. Your declaration

I solemnly and sincerely acknowledge and declare that:

- the KiwiSaver funds are released to me as if I have reached the New Zealand superannuation qualifying age, **and**
- after the withdrawal of the funds, I am no longer eligible to receive government contributions or compulsory employer contributions in relation to my future contributions, if any.
- I understand that personal information provided in this form will be used by the Manager, the Administration Manager and the Supervisor (including their related entities) to process my withdrawal request and to administer my membership of the NZ Funds KiwiSaver Scheme including satisfying the requirements of the AML/CFT Act (this may include using my personal information for the purposes of electronic identity verification using various third party databases, and may be disclosed for these purposes to third parties where relevant, including my authorised financial adviser, Inland Revenue, or other government agency). I acknowledge I have the right to access and correct this information.
- I understand that where my principal place of residence has not been New Zealand, I am not entitled to Government contributions during that period. Any Government contributions claimed by the Manager on my behalf during that period will be deducted from my withdrawal amount and returned to Inland Revenue.
- I understand that my withdrawal value might fluctuate and will be based on the unit price(s) applying at the date when my withdrawal request is processed and will be adjusted for any tax liability, fees and expenses.
- I acknowledge that on payment of the withdrawal amount to the bank account specified in this form, I will have no further claim against the NZ Funds KiwiSaver Scheme in relation to such payment.
- I acknowledge that if I withdraw my total NZ Funds KiwiSaver Scheme account balance, my membership in the NZ Funds KiwiSaver Scheme will end.

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

- might need to seek and obtain information that is held by any other person or organisation that the Supervisor 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 Supervisor on request, **and**
- will use and disclose the information about my life-shortening congenital condition 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

Signature of member

Day Month Year

Declared at (location)

Before me

(Justice of the Peace, Solicitor, Notary Public or other person authorised to take a statutory declaration under the Oaths and Declarations Act 1957)

Name

Signature

Occupation

Insert stamp here

Checklist

I have:

- ☐ **completed sections 1, 2, 3 and 4 and**
- ☐ **signed and dated Section 5 in the presence of a person authorised to take a statutory declaration, and**
- ☐ **had Section 6 completed by my doctor.**

I attach for myself and my spouse/partner:

- ☐ **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.**

6. Your doctor's declaration of your life-shortening congenital condition

Patient's name

Title | First name | Middle name(s) | Surname

Patient's address

Street

Suburb | Town / City | Postcode

Doctor/specialist's name

Clinic residential address (not PO Box)

Street

Suburb | Town / City | Postcode

Phone number

Email

I certify that

- I am a registered medical practitioner with the Medical Council of New Zealand, **and**
- the above-named is a patient of mine **and** (select option 1 or 2 below):

Option 1

The above-named suffers from the following life-shortening congenital condition, which is listed in the KiwiSaver Regulations:

☐ **Down's syndrome** ☐ **Cerebral palsy** ☐ **Huntington's disease** ☐ **Fetal alcohol spectrum disorder**

OR

Option 2

☐ **(a) the condition is a life-shortening congenital condition (i.e. one that is expected to reduce life expectancy below age 65 for the member or for persons in general with this condition), and**

☐ **(b) the member suffers from the condition.**

Signature

Signature of doctor/specialist

Day | Month | Year

☐ **Reports/records attached**

Medical practice stamp