WATERFRONT INDUSTRY SUPERANNUATION FUND

BENEFIT CLAIM FORM

EMPLOYER: NUMBER ______________ NAME __________________________________

MEMBER NUMBER _____________ ☐ WITHDRAWAL CODE

SURNAME ____

FIRST NAMES ____

DATE OF BIRTH _____/__________/______

DATE EMPLOYMENT
FINISHED OR DEATH _____/__________/______

ADDRESS OF MEMBER
(for death also enter full name of Beneficiary)

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DEATH ONLY - NAME AND ADDRESS OF ESTATE ADMINISTRATOR

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THE ABOVE INFORMATION IS CERTIFIED CORRECT:

AUTHORISED OFFICER __________________________ _____________________
(Signature) (Date)

WITHDRAWAL CODES

N	Retirement Age 60 or over	**I**	Ill Health/Disablement
R	Redundancy	**W**	Resignation
D	Death	**T**	Transfer
F	Dismissed		

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