



CLERICAL MEDICAL

Group Additional Voluntary Contributions Plan

Member application form

Please complete in CAPITAL LETTERS and where appropriate.

1. Personal details

Name of pension plan	
Mr/Mrs/Miss/Ms or other title	Surname
Full forename(s)	
Date of birth (DD/MM/YYYY) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
National Insurance number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Unique member reference number (as advised by your employer) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Additional employee reference (Show here any additional item which your employer has asked for eg department, location, payroll number etc.) <input type="text"/>	

2. New contributions

I wish to **commence** paying additional voluntary contributions (AVCs) as shown below. Please commence deduction from my pay as soon as possible.

Contribution £ per week/month* or % of pay*

I wish to pay a **single lump sum** contribution. Please deduct from my salary as soon as possible.

Contribution £

(*Delete whichever does not apply)

3. Changing contributions

I wish to **change** the amount of my AVCs as shown below. Please commence deduction from my pay at this new rate as soon as possible.

Contribution

From £ per week/month* or % of pay*

To £ per week/month* or % of pay*

(*Delete whichever does not apply)

