CINSF
COOK ISLANDS NATIONAL SUPERANNUATION FUND

TERMINAL ILLNESS BENEFIT
FOR PENSIONER

FULL PAYMENT REQUEST

PLEASE READ THIS SECTION BEFORE YOU START COMPLETING THIS FORM.

The Trustee will only authorise payment of your Terminal Illness benefit if, after considering relevant medical evidence, it considers you are suffering an illness that poses a serious and imminent risk of death.

1. Member details – Cook Islands National Superannuation Fund

RMD Number		CINSF Member Number
Title	☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Other	
First name(s)		
Surname		
Residential Address		
Phone Numbers	Home Phone	Mobile Phone
Email Address		Gender ☐ Male ☐ Female
Date of Birth (DD/MM/YY)	___ / ___ / ___	Final contribution date ___ / ___ / ___

Step 2 – Payment Details:

☐ please make payment by direct credit to my current bank account held on your records or

☐ attached a copy of my bank statement or letter of changes to my bank account.

Step 3 – Terminal Illness for Pensioners:

For a Terminal Illness full payout:
- ask your doctor to complete the declaration below:

DOCTOR'S DECLARATION OF TERMINAL ILLNESS FOR PENSIONERS

PATIENT

Full Name

First Name (s)   Surname

Address

DOCTOR

I, Doctor

of

Street Address   Island/City/State/Country

Daytime Number   Mobile

Email Address

Certify that:
- I am registered medical practitioner with the Medical Council of the Cook Islands or with an equivalent registration regime outside the Cook Islands.
- 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 a terminal illness that poses a serious and imminent risk of death.

Please find attach a medical report(s) with a brief description of the patient's condition:

_____   ____ / ____ / ____

Signature of Medical Practitioner   Date

Step 4 – Declaration

I certify that the information I have provided on this form is true and correct.

Signature   Date

CINSF Office Use Only

Checked by:	
Balance Available:	$
○	Verify that Pensioner has complete Step 1 and Step 2.
○	Verify that Doctor has complete Step 3 and has provide medical report

Process by Name & Sign:		Date	/ /
Manager for Approval		Date	/ /