HEALTH SECTOR OCCUPATIONAL PENSION SCHEME

**PENSIONS SERVICES ENGAGEMENT REQUEST FORM**

|  |  |  |  |  |  |
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| **EMPLOYER DETAILS** | | | | | |
| 1. | Name of Health Facility |  | | | |
| 2. | Location Address |  | | | |
| 3. | Postal Address |  | | | |
| 4. | Office Telephone Number(s) |  | | | |
|  | | | |
|  | | | |
| 5. | Fax Number (s) |  | |  | |
| 6. | Email Address |  | | | |
| 7. | Business Registration Number |  | | | |
| 8. | Tax Identification Number |  | | | |
| 9. | Social Security Number OF Health Facility (COMPLUSORY) |  | | | |
| **EMPLOYER CONTACT PERSON DETAILS** | | | | | |
| 10. | Name of 1st Contact Person ( schedule officer) |  | | | |
| 11. | Telephone Number (s) |  | | | |
|  | | | |
| 12. | Email Address |  | | | |
| 13. | Name of 2nf  Contact Person |  | | | |
| 14. | Contact Telephone Number (s) |  | | | |
|  | | | |
|  | | | |
| 15. | Email Address |  | | | |
| **FUND AMOUNT IS VALUE OF RECENT PAYMENT TO SSNIT AND THE NUMBER OF STAFF PAYMENT WAS FOR:** | | | | | | |
| Fund Amount: GH¢ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Number of Staff:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **DECLARATION** | | | | | |
| We warrant that the above statement and particulars are true. We hereby agree that this Declaration shall be held promissory and of continuing effect and shall form the basis of and be deemed to be incorporated in the Contract between us and the Enterprise Trustees Limited.  Official Stamp & Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature (on Behalf of Employer)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
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| ***FOR OFFICIAL USE ONLY*** | |
| *ASSIGNED FUND MANAGER* |  |
| *STAFF ASSIGNED TO WORK ON FORM* |  |
| *VIRTUAL ACCOUNT NUMBER* |  |
| *COMMENTS:* |  |
|  | |
| *APPROVED BY:* |  |
| *POSTION:* |  |
| *SIGNATURE:* |  |
| *DATE:* |  |