MCB Capital Markets

RETIREMENT PLAN AMENDMENT FORM

This form can be filled in on a computer; alternatively please print and complete fields in CAPITAL letters using black ink and tick (✓) where appropriate.

The Manager - MCB Investment Management

Client Name:

Address:

Sir/ Madam,

Retirement Plan Reference:

☐ Please **amend** the above mentioned Plan as follows:

☐ Investment Amount*/Choice

Sub-Fund	Class	Rs
MCB 2025 Target Date Fund	MCB2025TDF - Retail Accumulation Class	
MCB 2030 Target Date Fund	MCB2030TDF - Retail Accumulation Class	
MCB 2035 Target Date Fund	MCB2035TDF - Retail Accumulation Class	
MCB 2040 Target Date Fund	MCB2040TDF - Retail Accumulation Class	
Investment Total - Rs		0

☐ Retirement Age*

☐ Annual Escalation ☐ 0% ☐ 5% ☐ 10% ☐ 15%

☐ Insurance Cover* ☐ 25% ☐ 50% ☐ 100%

☐ Account to be debited

☐ Please **transfer** all my holdings in the above Plan to Plan number

☐ Please **cancel** the above Plan.

DECLARATION OF CONTINUED GOOD HEALTH**

Since your last declaration of health dated

1. Has there been any change in your state of health or have you attended, or been advised to attend, for any treatment, consultation or tests at any hospital, clinic or surgery, or consulted any member of the medical profession?

2. Have you changed or have you any intention of changing your occupation or country of residence?

3. Has any application for life or disability insurance on your life been postponed, declined, withdrawn or had special terms imposed?

* Please note that any **increase** to this factor requires the completion of the Declaration of Continued Good Health (within the same limits) or may be subject to additional medical tests and increased insurance rates.

** To be filled in only when there is an increase in the factors denoted by a *.

Initials: _____

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I hereby declare that to the best of my knowledge and belief the answers given are true and complete and that I have not withheld any material facts from the Insurer. I consent to the Insurer seeking medical information from any doctor who at any time has attended me and I authorise the giving of such information.

I confirm that I have read over any statements or answers not filled by me in my own handwriting and that they are correct.

Please sign below:

Signature:

Date: / / (dd/mm/yyyy)