

Administrator's
photograph
(as at the time
of filling
this form)

PPF PENSIONS FUND

The Director General,
PPF Pensions Fund,
P.O. Box 72473,
Dar es Salaam, Tanzania.
Tel. +225 22 2113919-22/2110642
Fax: +255 22 2117772
Email: ppf@ppftz.org



M/s.....
.....
.....
Tel.
Fax.
Official Email
Date:

RE: CLAIM FORM FOR SURVIVOR BENEFIT

This form should be filled jointly by the employer of the Deceased member and the Administrator of Estate of the Deceased member.

(Warning: Any person who the Deceased member without lawful excuse misrepresents or fails to disclose material facts commits an offence and shall be liable under Section 45 of the PPF Act Cap 372.)

We request you to process the benefits as per the details given hereunder (fill in triplicate):

1.	DECEASED MEMBER/PENSIONER PARTICULARS	
	Name of the Deceased Member/Pensioner (First/Middle/Surname)	
	Membership Number	
	Date of Death (dd/mm/yyyy)	
2.	EMPLOYER'S PARTICULARS	
	Employer's Registration Number	
3.	ADMINISTRATOR'S PARTICULARS	
	Name of Administrator (First/Middle/Surname)	
	Physical Address	
	P. O. Box	
	Region	
	Telephone Number	
4.	ADMINISTRATOR'S BANK DETAILS	
	Name of the Bank	
	Account Name	
	Account Number	
	Branch Name	
	Region	
5.	PREVIOUS PAYMENT DETAILS/PARTICULAR	
	Amount of Death Gratuity/Commuted Pension Lumpsum Paid	
	Cheque Number	
	Date Cheque Issued	
	Amount of Monthly/Survivor's Benefit Payable	
	Effective Date	
6.	DOCUMENTS REQUIRED	
	(a) Certified Copy of Death Certificate/Certificate of Death	
	(b) Certified Copy of Marriage Certificate/Birth Certificates	
	(c) Certified Copy of Letters of Probate and Administrator	
	(d) Certified Copy of Administrator's Bank Card (by the Bank Manager)	
	(e) Certified Copy of an Oath Swearing Dependency on the Deceased Member	
Administrator's Name		Signature
Name of Authorised Officer		
Telephone Number		
Signature		
That we make this solemn declaration conscientiously believing the same to be true and in accordance with the oaths and statutory declaration Act [CAP 34 R. E. 2002]		

FOR OFFICIAL USE ONLY

Deceased Member's File Number:

Date Claim Form Received:

Are the Employer Details Complete?

YES

NO

Are the Administrator Details Complete?

YES

NO

Are the Bank Details Complete?

YES

NO

Are all the required Documents attached?

YES

NO

Name of paying Supervisor:

Signature

Date