This Form is supplied free of charge. Please ensure the Form is fully and properly completed. Failure to do so will result in delays in processing your benefits

POSTAL CORPORATION OF KENYA
STAFF PENSION SCHEME

NHIF Building
9th Floor
1st Ngong Avenue
P.O. Box 46621-00100
Tel: 2737976/2720065
Nairobi

PENSION SCHEME MEMBERS LEAVERS FORM

PART A

1. Full Names: ----------
2. Employer ----------
3. Employment/Payroll No. ----------
4. Sex: ----------
5. Rank ----------
6. Scale ----------
7. Date of Birth ---------- Day --------- Month ---------- year--------
8. Date of Appointment ---------Day---------- Month ---------- year----------
   (*attach Certified Copy of Appointment Letter)*
9. Date of Retirement ----------Day ----------Month ----------year ----------
   (attach Certified Copy of Retirement Letter)
10. Last Date of Service ----------Day ----------Month ----------year ----------
11. Total Pensionable Service to Date of Leaving Service (in months) ----------
12. Age at leaving Service ----------Years -------Months ----------Days----------
13. Cause For Leaving ----------
14. Monthly Pensionable Salary At Time of Retirement (Kshs)----------
    (attach Certified copy of Last Pay Slip and/or Payment Voucher)
15. Monthly Pensionable Salary Progression in the last year of pensionable service

    (Kshs)----------

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16. Final Pensionable salary during Last Year of Pensionable Service

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17. Please indicate whether there have been any breaks in service if yes, give reasons, duration, timing and monthly pensionable salary during each break.

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19. **TYPE OF PENSION BENEFIT PAYABLE TO MEMBER (Please tick one of the below)**

☐ **Normal Pension** ☐ **Deferred Pension**

☐ III –health Pension Attach ☐ Return of contributions

(Certified copy of Medical Certificate)

☐ Early pension (if aged 50 but less than 55)

If Ill-health and in case a Member is permanently injured in the actual discharge of his duty, please indicate if:

(a) such injury occurred without Member's default (Yes/No) ----------

(b) such injury occurred in circumstances specifically attributable to the nature of the Member's duty (Yes/No)----------

(c) the Member's capacity to contribute to his own support is (medical certificate necessary):-

Slightly impaired ----------

Impaired ----------

Materially impaired ----------

Totally destroyed ----------

If Normal, Deferred, III-health or Early Pension is chosen, please state proportion of pension to be commuted:_____%(Subject to Income Tax limits which is currently 25%)

20. **Forwarding Telephone/ Address**

_____

_____

_____

_____

Contact Telephone/
Address After Retirement

_____

_____

20. Bank Details:

Account No. _____

Type of Account
(Savings or Current) _____

Bank Name _____

Branch: _____

Address:_____

_____

_____

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21. Employer Certificate

Certified to be Correct ----------Date ----------
Signed

Full Names of the Officer Signing ----------

Rank of the Officer Signing ----------

Official Rubber Stamp ----------

PART B

FOR SECRETARIAT USE ONLY

Form checked by: _____ Verified by: _____

Data capture checked by:-_____Verified by: _____

Deferred pension

22. CONSENT.

I _____
(Full name)

Of _____
(Address)

_____
(Phone number)

_____
(Email)

On this day _____
(Date)

have read, understood, and accept each of the statements in this document and consent to personal and sensitive information about me being collected, used and disclosed by you as indicated above to facilitate payment of retirement benefits.

_____
(Sign)

WITNESS

Signed for and on behalf of _____
(Sign)

_____
(Print name)