

SWAZILAND NATIONAL PROVIDENT FUND (BENEFIT) REGULATIONS  
(Under section 44 of the King's Order-In-Council)

*Date of commencement: 1st July, 1975.*

*Citation.*

1. These regulations may be cited as the Swaziland National Provident Fund (Benefit) Regulations, 1975.

*Claims to be made on approved form.*

2. (1) A claim for benefit shall be made in writing to the Chief Executive Officer on an appropriate form prescribed in the Schedule to these regulations.

(2) Applicants for retirement, age and emigration benefits shall lodge their claims at the head office of the Fund not less than twenty-one days before payment is required.

*Chief Executive Officer's discretion to treat one claim for another.*

3. The Chief Executive Officer may in his discretion treat a claim for any benefit as a claim for any other benefit.

*Statutory declaration.*

4. (1) The Chief Executive Officer may require any person who has made an application for benefit to declare under oath or on affirmation before a Justice of the Peace or Commissioner for Oaths the truth of any statement of fact made by him in his application or in connection therewith.

(2) Any person who makes a false statement or representation or who produces or furnishes any information which he knows to be false in a material particular, shall be guilty of an offence and may be liable on conviction to a fine not exceeding E100 or imprisonment for a term not exceeding three months, or both.

*Requirement on claimants to do certain things in support of claim.*

5. The Chief Executive Officer may require any person claiming a benefit —
- (a) to attend at such office or place as he may reasonably require to obtain further evidence of identity and of entitlement as is in his opinion necessary to substantiate the benefit claim;
  - (b) to undergo such examination by a medical practitioner at the expense of the Fund as he may require to determine the claimant's age, the degree of his physical or mental disability or the extent of his capacity to earn a livelihood, and may use the report of such examination as evidence in deciding eligibility for benefit; and
  - (c) to furnish such evidence as he may reasonably require to establish the death of a member, the relationship to the deceased member of any person claiming a survivor's benefit or appearing to him to be eligible for a benefit.

*Information for tracing a member or his relatives.*

6. A contributing employer shall furnish such information as the Chief Executive Officer may require for the purpose of tracing a member or his dependent relatives.

*Amount of benefit.*

7. (1) The amount of benefit payable by the Chief Executive Officer from a member's main account shall be the total of statutory contributions paid by contributing employers in respect of that member, together with interest at a rate to be declared annually by the Board in respect of each complete year during which no payment of benefit has been paid out of the account of the member, calculated on the amount standing to the credit of that account on the first day of such year.

(2) The amount of benefit payable by the Chief Executive Officer from a member's savings account shall be the total, or such lesser sum as the member claims, of supplementary contributions paid by contributing employers in respect of that member, together with interest at a rate to be declared annually by the Board in respect of each complete year during which no payment of benefit has been paid out of the account of the member, calculated on the amount standing to the credit of that account on the first day of such year.

(3) If a member has contributed on his own behalf to the Fund in accordance with section 20 of the Order, the benefit payable under paragraph (1) of this regulation shall be increased by the amount of any contributions made to the Fund by such employee, together with interest at a rate to be declared annually by the Board in respect of each complete year during which no payment of benefit has been paid out of the account of the member, calculated on the amount standing to the credit of that account on the first day of such year.

*Payment of benefit.*

8. (1) Any benefit, other than emigration benefit may in the discretion of the Chief Executive Officer be paid by way of monthly or quarterly instalments of not less than the monthly or quarterly wage of the member at the time of payment of the last statutory contribution under the Order.

(2) Any sum payable by way of benefit shall be paid by cheque or, where this is impracticable, by such other method as the Chief Executive Officer may decide.

(3) If any cheque or other instrument of payment has been sent by ordinary or registered post, delivery thereof shall, unless the contrary is proved, be deemed to have been effected at the time at which a letter would be delivered in the ordinary course of the post.

(4) If the Chief Executive Officer is satisfied that a cheque or other instrument of payment has been lost or destroyed, he may on receipt of a duly executed indemnity issue a replacement for such cheque or other instrument of payment.

*Payment to member under disability.*

9. If the Chief Executive Officer is satisfied that a member of the Fund is for any reason unfit to manage his own affairs and no person has been appointed *curator bonis* or similar authority in respect of that member by the High Court, the Chief Executive Officer may, if he thinks fit, pay such member's benefit to any other person who satisfies the Chief Executive Officer that he is a proper person to receive the amount on the member's behalf, and will use the amount for the maintenance and benefit of the member disabled and his dependants.

*Receipt of benefit to be full discharge.*

10. The receipt of a member of the Fund or of his legal representative or of a person authorised to receive the benefit on his behalf, shall be a full and sufficient discharge to the Fund for the sum specified therein.

*Unclaimed monies.*

11. (1) Any amount standing to the credit of a member of the Fund eligible for age benefit in respect of whom no payments have been received for five years, and in respect of which no claim for benefit has been received before the end of such period shall be regarded as an unclaimed balance and shall be transferred to the Reserve Account.

(2) The Chief Executive Officer shall give three months, notice by publication in the Gazette of all unclaimed balances to be transferred to the Reserve Account.

(3) Any amount which has been transferred to the Reserve Account shall be paid to any person who can show a legal title thereto, provided he gives such indemnity to the Fund as the Chief Executive Officer may require.

(4) In January of each year, the Chief Executive Officer shall cause to be published in the Gazette and in a newspaper circulating in Swaziland a list containing the names of any persons in respect of whom unclaimed amounts have been transferred to the Reserve Account in terms of paragraph (1) hereof.

SCHEDULE  
(Replaced L.N.129/1990.)

LIDLELANTFONGENI

SWAZILAND NATIONAL PROVIDENT FUND  
CLAIM FOR RETIREMENT BENEFIT

Persons claiming this benefit must have attained the age of 45 years and retired from regular wage-earning employment

1. Name and address of claimant (IN BLOCK LETTERS)  (a) Surname ..... (b) Other Names ..... (c) Graded Tax Number ..... (d) Year of birth ..... (e) Date of Joining NPF ..... (f) Address for correspondence ..... .....	For Office use only
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(g) Residential address .....

2. Claimant's present or last employer

(a) Employer's full name and address

Account Number  
(if known)

(b) Claimant's occupation and works number (if any).....

(c) If not employed, state date left the above-mentioned employer .....

3. Claimant's previous employers

Employer' full names	Claimant's occupation & works No. (if any)	Period Employed		Employer's Account No.
		From	To	
(a) .....				
(b) .....				
(c) .....				

(If this space is insufficient, please use separate sheet)

4. Declaration of retirement:

I declare that I am over 45 years of age and that —

(a) I am self-employed as a.....

(b) I have already retired from regular employment with effect from.....

} Complete and delete as applicable

5. Claim for benefit:

I hereby claim a retirement benefit under the Swaziland National Provident Fund Order 1974, and I declare that the particulars in support of this claim are correct to the best of my knowledge and belief.

I wish the benefit payment to be sent to me at the following address:

.....
.....
.....
.....

Claimant's Signature (or mark):

.....

Date.....

Attesting witness:

(A Labour Officer, or Social Welfare Officer,  
or Minister of Religion, or Legal Practitioner,  
or Bank Manager, or Medical Practitioner, or  
Commissioner of Oaths)

}	Signature .....
	Full name.....
	.....
	(IN BLOCK LETTERS
	Designation .....
	.....
}	Address.....
	.....

This form should be sent to:

The Chief Executive Officer,  
Swaziland National Provident Fund,  
P.O. Box 1857,  
MANZINI.

LIDLELANTFONGENI

NPF 32

SWAZILAND NATIONAL PROVIDENT FUND

CLAIM FOR AGE BENEFIT

Persons claiming this benefit must have attained the age of 50 years

1. Name and address of claimant  
(IN BLOCK LETTERS)
- (a) Surname .....
- (b) Other names .....
- .....
- (c) Graded Tax Number .....
- (d) Year of birth.....
- (e) Date of joining National Provident Fund .....
- (f) Address for correspondence and benefit payment ..
- .....
- .....
- (g) Residential address .....
- .....
- .....

For Office use only

2. Claimant's present or last employer
- (a) Employer's full name and address:
- .....
- .....
- .....
- (b) Claimant's occupation and works number (if any):
- .....
- (c) If not employed, state date left the above-mentioned employer:
- .....

Account Number  
(if known)

.....

3. Claimant's previous employers

Employer's full names & addresses	Claimant's occupation & Works No. (if any)	Period employed		Employer's Account No.
		from	to	
(a) .....				
.....				

(b)

(c)

(If this space is insufficient, please write details on a separate sheet)

4. Claim for benefit

I hereby claim a benefit having attained the age of ..... years, under the Swaziland National Provident Fund Order, 1974, and I declare that the particulars in support of this claim are correct to the best of my knowledge and belief.

I wish the benefit payment to be sent to me at the following address:—

Box with four horizontal dotted lines for address details.

Claimant's Signature (or mark):

.....

Date.....

Attesting witness:

(A Labour Officer, or Social Welfare Officer, or Minister of Religion, or Legal Practitioner,

Signature .....



or Bank Manager, or Medical Practitioner, or  
Commissioner of Oaths)

Full name.....

.....  
(IN BLOCK LETTERS

Designation .....

.....

Address.....

.....

This form should be sent to:

The Chief Executive Officer,  
Swaziland National Provident Fund,  
P.O. Box 1857,  
MANZINI.

LIDLELANTFONGENI

NPF 33

SWAZILAND NATIONAL PROVIDENT FUND

CLAIM FOR INVALIDITY BENEFIT FOR MEMBER SUFFERING  
FROM PHYSICAL DISABILITY

NOTE: If a member is unemployable by reason of mental disability, a claim may be  
made on his behalf on Form NPF 33M.

1. Name and address of claimant	For Office use only
(IN BLOCK LETTERS)	.....
(a) Surname .....	
(b) Other names .....	
.....	
(c) Graded Tax Number .....	
(d) Year of birth.....	
(e) Date of joining NPF.....	
(f) Postal address.....	
.....	
.....	
(g) Residential address .....	

.....  
.....

2. Grounds of claim etc.:

- (a) Nature of the physical disability which renders the claimant unemployable: .....  
.....
- (b) Nature of supporting evidence: .....  
.....
- (c) Documents attached: .....
  - (i) .....
  - (ii) .....
  - (iii) .....
- (d) Name and address of hospital or other treatment centre where claimant has been treated for the disability .....  
.....

3. Claimant's employment:

- (a) Full name and address of the claimant's last employer who was a contributing employer under this order: .....  
.....
- (b) Claimant's occupation, and works number, if known.....  
.....
- (c) Date or approximate date, when claimant last worked for that employer: .....  
.....19 .....

For Office use only

4. If disability caused by accident at work

- (a) State whether workmen's compensation has been claimed, and if so, give the workmen's compensation office reference No.: .....  
.....
- (b) State briefly where, and how, the accident happened .....  
.....

(If insufficient space, please attach statements to this form)

Claim for Provident Fund benefit:

5. I hereby declare that I am suffering from:—

- \* Delete as applicable      \* Permanent total incapacity
- \* Partial incapacity of a permanent nature and that I am over the age of Fifty years.
- \* Partial incapacity of a permanent nature as a result of which I am unable to earn a reasonable livelihood.

I further declare that the particulars supplied in support of this claim are correct to the best of my knowledge and belief.

I wish the benefit payment to be sent to me at the following address:—

.....
.....
.....
.....

Claimant's signature (or mark):

.....

Date.....

Attesting witness:

(A Labour Officer, or Social Welfare Officer, or Minister of Religion, or Legal Practitioner, or Bank Manager, or Medical Practitioner, or Commissioner of Oaths)

}	Signature .....
	Full name.....
	.....
	(IN BLOCK LETTERS
	Designation .....
	.....
}	Address.....
	.....

This form should be sent to:

The Chief Executive Officer,  
Swaziland National Provident Fund,  
P.O. Box 1857,  
MANZINI.

LIDLELANTFONGENI

NPF 33M

SWAZILAND NATIONAL PROVIDENT FUND

CLAIM FOR INVALIDITY BENEFIT ON BEHALF OF MEMBER  
SUFFERING FROM MENTAL DISABILITY

1. Name and address of claimant	For Office use only
(IN BLOCK LETTERS)	.....
(a) Surname .....	
(b) Other names .....	
.....	
(c) Graded Tax Number .....	
(d) Year of birth.....	
(e) Date of joining National Provident Fund .....	
(f) Postal address.....	
.....	
.....	
(g) Residential address .....	
.....	
.....	

2. Grounds of claim:

(a) When did the member's mental disability first occur? .....

.....

(b) Has the member been subject to an Order of the High Court? If so give particulars:

.....

.....

(c) Name and address of hospital or other treatment centre where member has been treated for disability:.....

.....

(d) Name and address of Doctor to whom reference may be made for a report on the circumstances of the claim: .....

.....

.....

- (e) Documents attached in support of applicant's claim that the member is unemployable by reason of mental disability: .....
- (i) .....
- (ii) .....
- (iii) .....

<p>3. Member's employment:</p> <p>(a) Full name and address of the member's last employer who was a contributing employer under this order: .....</p> <p>.....</p> <p>.....</p> <p>(b) Member's occupation and works number if known</p> <p>.....</p> <p>.....</p> <p>(c) Date or approximate date, when member last worked for that employer: .....</p> <p>.....19 .....</p>	<p>For Office use only</p>
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4. I hereby declare that the member whose particulars are given overleaf is in my care and control, and that I am responsible for his/her maintenance and support.

I further declare that the particulars given in support of this claim for the member's benefit are correct to the best of my knowledge and belief.

I wish the benefit payment to be sent to me at the following address:

.....
.....
.....
.....

Applicant's signature (or mark):

.....

Date.....

Attesting witness:

(District Commissioner, Legal Practitioner, or  
Commissioner of Oaths)

Signature .....

Full name.....

.....

(IN BLOCK LETTERS

Designation .....

.....

Address.....

.....

This form should be sent to:

The Chief Executive Officer,  
Swaziland National Provident Fund,  
P.O. Box 1857,  
MANZINI.

LIDLELANTFONGENI

NPF 34

SWAZILAND NATIONAL PROVIDENT FUND  
CLAIM FOR EMIGRATION BENEFIT

1. Name and address of claimant	For Office use only
(IN BLOCK LETTERS)	
(a) Surname .....	
(b) Other names .....	
.....	
.....	
(c) Graded Tax Number .....	
(d) Year of birth.....	
(e) Date of joining NPF.....	
(f) Postal address.....	
.....	
.....	

- .....  
 (g) Residential address .....
- .....
- .....
- (h) Passport number.....
- (i) Place and date of issue.....
- .....

2. Claimant's present employer or last employer
- (a) Employer's full name and address .....
  - .....
  - .....
  - (b) Claimant's occupation .....
  - (c) Works number (if any) .....
  - (d) Date when claimant left employment or is leaving present employment .....
  - .....

3. Grounds of claim
- (a) Date on which claimant emigrated or is about to emigrate from Swaziland .....
  - .....
  - (b) Address to which communications should be sent in country of destination .....
  - .....
  - .....
  - .....

4. Claimant's previous employers

Employer's full names & addresses	Claimant's occupation & Works No. (if any)	Period employed		Employer's Account No.
		from	to	
(a) .....				
.....				
.....				
(b) .....				
.....				
.....				
.....				

(c) .....

.....

.....

.....

(If this space is insufficient, please write details on a separate sheet)

5. Declaration and Claim

I declare that I am about to emigrate/have emigrated from Swaziland and that I have no present intention of returning to Swaziland. I therefore claim an Emigration benefit under the Swaziland National Provident Fund Order, 1974.

I further declare that the particulars in support of this claim are correct to the best of my knowledge and belief.

Signature of claimant (or his mark):

.....

Date.....

Attesting witness:

(A Labour Officer, or Social Welfare Officer,  
or Minister of Religion, or Legal Practitioner,  
or Commissioner of Oaths)

Signature .....

Full name.....

.....

(IN BLOCK LETTERS

Designation .....

.....

Address.....

.....

This form should be sent to:

The Chief Executive Officer,  
Swaziland National Provident Fund,  
P.O. Box 1857,  
MANZINI.

SWAZILAND NATIONAL PROVIDENT FUND  
 CLAIM FOR BENEFIT BY WIDOW, OR WIDOWER, OR  
 NOMINEE OF DECEASED MEMBER

<p>1. Particulars of deceased member:          (IN BLOCK LETTERS)</p> <p>(a) Surname .....</p> <p>(b) First name .....</p> <p>.....</p> <p>(c) Graded Tax Number .....</p> <p>(d) Date of death.....</p> <p>(e) Documentary evidence of death attached (for example from hospital, funeral director's account etc.)</p> <p style="padding-left: 20px;">(i) .....</p> <p style="padding-left: 20px;">(ii) .....</p> <p style="padding-left: 20px;">(iii) .....</p> <p>(f) If there is no documentary evidence state briefly circumstances of death and give the names and addresses of two persons who can confirm the fact:.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p style="text-align: center;">For Office use only</p> <p>.....</p>
<p>2. Employment of deceased member:</p> <p>(a) Full name and address of member's last employer who was a contributing employer under the order:</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>(b) Member's occupation, and works number if known:</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p style="text-align: center;">Account No.</p> <p>.....</p>

3. Particulars of claimant

For Office use only

(IN BLOCK LETTERS)

- (a) Surname .....
- (b) Other names .....
- (c) Graded Tax Number .....
- (d) Postal address.....
- (e) Residential address .....
- (f) Of the following three statements, delete the two which do not apply: .....

  - (i) The claimant is the widow of the member, with whom she was cohabiting at the time of his death.
  - (ii) The claimant is the widower of the member, with whom he was cohabiting at the time of her death.
  - (iii) The claimant is one of the family of the member, nominated by the member to receive the benefit payable on the member's death.

- (g) Where (iii) of the previous question applies, state claimant's relationship to the member:  
.....

4. Declaration and claim:

I declare that the particulars given in support of this claim are correct to the best of my knowledge and belief and accordingly I claim the benefit due from the Swaziland National Provident Fund on the death of the member of the Fund named overleaf.

I wish the benefit payment to be sent to me at the following address.

.....
.....
.....
.....

Claimant's signature (or mark):

.....

Date.....

Attesting witness:

(A Labour Officer, or Social Welfare Officer,  
or Minister of Religion, or Legal Practitioner,  
or Bank Manager or Medical Practitioner, or  
Commissioner of Oaths)

Signature .....

Full name.....

.....

(IN BLOCK LETTERS)

Designation .....

.....

Address.....

.....

This form should be sent to:

The Chief Executive Officer,  
Swaziland National Provident Fund,  
P.O. Box 1857,  
MANZINI.

LIDLELANTFONGENI

NPF 36

SWAZILAND NATIONAL PROVIDENT FUND  
CLAIM FOR BENEFIT BY ADULT FORMERLY DEPENDENT  
ON DECEASED MEMBER

<p>1. Particulars of deceased member: (IN BLOCK LETTERS)</p> <p>(a) Surname .....</p> <p>.....</p> <p>(b) First name .....</p> <p>(c) Graded Tax Number .....</p> <p>(d) Date of death.....</p> <p>(e) Documentary evidence of death attached (for example, death certificate, certificate from hospital, funeral director's account etc.)</p> <p>(i) .....</p> <p>(ii) .....</p>	<p>} As on Graded Tax documents</p>	<p>For Office use only</p> <p>.....</p>
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- (iii) .....
- (f) If there is no documentary evidence state briefly circumstances of death and give the names and addresses of two persons who can confirm the fact:.....  
 .....  
 .....  
 .....  
 .....

2. Employment of deceased member:
- (a) Full name and address of member's last employer who was a contributing employer under the order:  
 .....  
 .....
  - (b) Member's occupation, and works number if known:  
 .....
  - (c) Date, or approximate date, when member last worked for that employer:  
 .....

Account number

.....

3. Particulars of claimant  
(IN BLOCK LETTERS)
- (a) Surname .....
  - (b) Other names .....
  - (c) Graded Tax Number .....
  - (d) Postal address.....  
 .....
  - (e) Residential address .....
  - (f) Age:.....
  - (g) Relationship to deceased .....
  - (h) Full names & addresses of claimant's employer (if any).....
  - (i) Give the reason(s) why the claimant was wholly, or partly, dependent on the deceased member.....
  - (j) How long had the claimant been wholly, or partly dependent on the deceased member  
 .....

For Office use only

- (k) Extent of claimant's dependency on member:.....
- (i) Approximate amount of claimant's weekly or monthly CASH income from all sources
  - (ii) Approximate amount which the deceased member, while in employment, contributed in cash each week or month to the claimant's support: .....
  - (iii) Apart from cash, if any, in what other ways did the member support or provide for the claimant? (Did he for example, provide accommodation, or food or clothing?) .....  
Give details.....  
.....

4. Declaration and claim:

I declare that I am a member of the family of the deceased person and that I was wholly or in part dependent on him for the ordinary necessities of life. Accordingly I claim benefit under the Swaziland National Provident Fund Order, 1974.

I further declare that the particulars given in support of this are correct to the best of my knowledge and belief.

I wish the benefit payment to be sent to me at the following address.

.....
.....
.....
.....

Claimant's signature (or mark):

.....

Date.....

Attesting witness:

(A Labour Officer, or Social Welfare Officer,  
or Minister of Religion, or Legal Practitioner,  
or Bank Manager or Medical Practitioner, or  
Commissioner of Oaths)

Signature .....

Full name.....

.....

(IN BLOCK LETTERS)

Designation .....

.....

Address.....

.....

This form should be sent to:

The Chief Executive Officer,  
Swaziland National Provident Fund,  
P.O. Box 1857,  
MANZINI.

LIDLELANTFONGENI

NPF 37

SWAZILAND NATIONAL PROVIDENT FUND  
APPLICATION FOR PAYMENT OF BENEFIT BY GUARDIAN OF  
MINOR CHILD(REN) FORMERLY DEPENDENT ON DECEASED  
MEMBER

<p>1. Particulars of deceased member: (IN BLOCK LETTERS)</p> <p>(a) Surname .....</p> <p>.....</p> <p>(b) First name .....</p> <p>(c) Social Security Number.....</p> <p>(d) Date of death.....</p> <p>(e) Documentary evidence of death attached (for example, death certificate, certificate from hospital, funeral director's account etc.)</p>	<p>As on Graded Tax documents</p>	<p>For Office use only</p> <p>.....</p> <p>NPF 101B requested on:</p> <p>.....</p>
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(f) If there is no documentary evidence state briefly circumstances of death and give the names and addresses of two persons who can confirm the fact:.....  
 .....  
 .....  
 .....  
 .....

Initials: .....

2. Employment of deceased member:

(a) Full name and address of member's last employer who was a contributing employer under the order:  
 .....  
 .....  
 (b) Member's occupation, and works number if known:  
 .....  
 (c) Date, or approximate date, when member last worked for that employer:  
 .....

Account number

.....

3. Particulars of child(ren):

Enter in the columns below particulars of each child, now in the care of the guardian, who was included in the family of the deceased member and who was wholly or in part dependent on him at the time of his death (or would but for his illness have been so dependent).

	First or only Child	Second Child	Third Child	Fourth Child	Fifth Child
(a) Child's surname	.....	.....	.....	.....	.....
First name	.....	.....	.....	.....	.....
Age	.....	.....	.....	.....	.....
(b) Relationship of child to deceased member	.....	.....	.....	.....	.....
(c) Present residential address of Child	.....	.....	.....	.....	.....
(d) Was child residing with & wholly supported by the	.....	.....	.....	.....	.....

deceased member?					
(e) If the answer to (d) is "NO" in what way did the deceased support or provide for the child? Give details	.....	.....	.....	.....	.....
	.....	.....	.....	.....	.....
	.....	.....	.....	.....	.....
	.....	.....	.....	.....	.....

4. Particulars of Guardian: For Office use only  
 (IN BLOCK LETTERS)

- (a) Surname .....
- (b) Other names .....
- (c) Graded Tax Number .....
- (d) Postal address.....  
 .....
- (e) Residential address .....
- .....
- (f) Age.....
- (g) Relationship, if any, to deceased.....  
 .....

--	--

5. Declaration, and application for payment:

I declare that I am the guardian of the child(ren) named overleaf, each one of whom is a member of the family of the deceased member named on page 1, and accordingly I apply for payment of the benefit due to the child(ren) under the Swaziland National Provident Fund Order.

I undertake to use the benefit for the maintenance and education of the child(ren) and to render such reports on the administration of the benefit as may be required.

I further declare that the particulars given in support of this application are correct to the best of my knowledge and belief.

I wish the benefit payment to be sent to me at the following address:

.....
.....
.....
.....

Guardian's signature (or mark):

.....

Date.....

Attesting witness:

(A Labour Officer, or Social Welfare Officer, or Minister of Religion, or Legal Practitioner, or Bank Manager or Medical Practitioner, or Commissioner of Oaths)

Signature .....

Full name.....

.....

(IN BLOCK LETTERS

Designation .....

.....

Address.....

.....

This form should be sent to:

The Chief Executive Officer,  
Swaziland National Provident Fund,  
P.O. Box 1857,  
MANZINI.

LIDLELANTFONGENI

NPF 38

SWAZILAND NATIONAL PROVIDENT FUND

CLAIM FOR SAVINGS BENEFIT

Persons can claim this benefit only after leaving employment:

Name and address of claimant	For Office use only
(IN BLOCK LETTERS)	.....
(a) Surname .....	
(b) Other name.....	
(c) Graded Tax Number .....	
(d) Year of birth.....	
(e) Date of joining NPF.....	

(f) Address for correspondence:  
 .....  
 .....

---

Claimant's last employer

(a) Employer's full name and address  
 .....  
 .....

(b) Claimant's occupation and works number (if any):  
 .....

(c) State date of leaving the above-mentioned employer's service:  
 .....

Account number  
(if known)  
 .....

Claimant's previous employers:

Employers' full names & addresses:	Claimant's occupation & Works No. (if any)	Period employed		Employer's Account No.
		from	to	
(a) .....				
(b) .....				
(c) .....				

(If this space is insufficient, please use separate sheet)

4. Claim for benefit:

I hereby claim a withdrawal benefit under the Swaziland National Provident Fund (Private Scheme) Withdrawal Benefit Regulations, 1975, and I declare that the particulars in support of this claim are correct to the best of my knowledge and belief.

I wish to receive the sum of E.....representing 40% of the capital sum paid into the Swaziland National Provident Fund on my behalf by my employer/former employer.

Please send the benefit to me at the following address:

Claimant's Signature (of mark):  
 .....  
 Date.....

Attesting witness:

(A Labour Officer, or Social Welfare Officer,  
or Minister of Religion, or Legal Practitioner,  
or Bank Manager, or Medical Practitioner, or  
Commissioner of Oaths)

}	Signature .....
	Full name.....
	.....
	(IN BLOCK LETTERS
	Designation .....
.....	
Address.....	
.....	

This form should be sent to:

The Chief Executive Officer,  
Swaziland National Provident Fund,  
P.O. Box 1857,  
MANZINI.

LIDLELANTFONGENI

NPF 38P

SWAZILAND NATIONAL PROVIDENT FUND  
CLAIM FOR PRIVATE SCHEME WITHDRAWAL BENEFIT

Name and address of claimant

(IN BLOCK LETTERS)

- (a) Surname .....
- (b) Other name.....
- (c) Graded Tax Number .....
- (d) Year of birth
- (e) Date of joining NPF.....

For Office use only

.....
NPF 20 sent
.....
Initials: .....
.....

<p>(f) Address for correspondence:  .....  .....</p>	
<p>Claimant's last employer</p> <p>(a) Employer's full name and address  .....  .....</p> <p>(b) Claimant's occupation and works number (if any):  .....</p> <p>(c) State date of leaving the above-mentioned employer's service:  .....</p>	<p>Account number  (if known)  .....</p>
<p>Name of employer's private pension or provident fund scheme:  .....  .....</p> <p>Membership Number (if any)  .....</p> <p>Total credit paid into S.N.P.F. by employer:  .....</p>	

4. Claim for benefit:

I hereby claim a withdrawal benefit under the Swaziland National Provident Fund (Private Scheme) Withdrawal Benefit Regulations, 1975, and I declare that the particulars in support of this claim are correct to the best of my knowledge and belief.

I wish to receive the sum of E.....representing 40% of the capital sum paid into the Swaziland National Provident Fund on my behalf by my employer/ former employer.

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Claimant's Signature (of mark):

.....

Date.....

Attesting witness:

(A Labour Officer, or Social Welfare Officer, or Minister of Religion, or Legal Practitioner, or Bank Manager, or Medical Practitioner, or Commissioner of Oaths)

}	Signature .....
	Full name.....
	.....
	(IN BLOCK LETTERS
	Designation .....
}	.....
	Address.....
	.....

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MANZINI.