

Please ensure that your application form/cheque is completely filled and signed before handing it over to our representative. We will notify you through email and SMS upon receipt of the application form.

برائے مہربانی اس بات کو یقینی بنائیے کہ آپ کا درخواست فارم / چیک ہمارے نمائندے کو دینے سے قبل مکمل طریقے سے پُر اور دستخط شدہ ہو۔ درخواست فارم موصول ہونے پر ہم آپ کو بذریعہ ای میل اور ایس ایم ایس مطلع کریں گے۔

PAKISTAN PENSION FUND <input type="checkbox"/>	ALHAMRA ISLAMIC PENSION FUND <input type="checkbox"/>	Current Age	* Expected Retirement Age
		* If expected retirement age is not provided, it would be assumed seventy (70) years	

LOAD DETAILS OF VOLUNTARY PENSION SCHEME

NAME OF VOLUNTARY PENSION SCHEME	TYPE OF SCHEME	FRONT-END LOAD
PAKISTAN PENSION FUND	CONVENTIONAL	3%
ALHAMRA ISLAMIC PENSION FUND	SHARIAH COMPLIANT	3%

DATE: _____ Please write in block letters using black ink

1. PARTICIPANT DETAILS (Mandatory Information)

PARTICIPANT APPLICANT'S NAME (as per CNIC / NICOP)			
FATHER'S/HUSBAND'S NAME			
CNIC / NICOP NO.		DATE OF BIRTH	
GENDER	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANSGENDER <input type="checkbox"/>	NTN NUMBER	
ZAKAT DEDUCTION	Yes <input type="checkbox"/> No <input type="checkbox"/> (If "No" please provide Zakat Affidavit)		
MARITAL STATUS	SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MOTHER MAIDEN NAME	

2. CONTACT DETAILS (Most Important and Mandatory Information)

RESIDENTIAL ADDRESS			
CITY / DISTRICT	POSTAL CODE	COUNTRY	
OFFICE/ BUSINESS ADDRESS			
CITY / DISTRICT	POSTAL CODE	COUNTRY	
MAILING ADDRESS (select one)	<input type="checkbox"/> RESIDENTIAL ADDRESS OR <input type="checkbox"/> OFFICE/ BUSINESS ADDRESS		
TELEPHONE No.	RES. <input type="checkbox"/>	OFF. <input type="checkbox"/>	EXT. <input type="checkbox"/> FAX No. <input type="checkbox"/>
EMAIL ADDRESS			
MOBILE No.	Participant Signature		

3. STATEMENT OF ACCOUNT DELIVERY INSTRUCTIONS

Please select any ONE nature of correspondence as per your convenience

☐ By Email (Statement of Account will be sent on transactions, Monthly and Half Yearly) OR ☐ By Post (Statement of Account will be sent on Transactions and Semi Annually)

NOTE: If No option is selected, Statement of Account will be sent Half Yearly through email and if email is not available, statement will be sent through Post. The Company may charge fee for physical statement subject to the requirements of the Constitutive Documents of the Scheme.

4. BANK DETAILS

BANK ACCOUNT TITLE			
COMPLETE BANK ACCOUNT No.		BANK NAME	
BRANCH NAME & ADDRESS		CITY	
IBAN			

5. DETAILS OF INVESTMENT ALLOCATION SCHEME & CONTRIBUTION

PLEASE SELECT ANY ONE ALLOCATION SCHEME ACCORDING TO WHICH YOUR CONTRIBUTIONS SHALL BE ALLOCATED IN THE SUB-FUND

HIGH VOLATILITY				MEDIUM VOLATILITY				LOW VOLATILITY				LOWER VOLATILITY				CUSTOMIZED ALLOCATION SCHEME			
✓	EQUITY	DEBT	MONEY MARKET	✓	EQUITY	DEBT	MONEY MARKET	✓	EQUITY	DEBT	MONEY MARKET	✓	EQUITY	DEBT	MONEY MARKET	✓	EQUITY	DEBT	MONEY MARKET
<input type="checkbox"/>	80%	20%	NIL	<input type="checkbox"/>	50%	40%	10%	<input type="checkbox"/>	25%	60%	15%	<input type="checkbox"/>	NIL	60%	40%	<input type="checkbox"/>	____%	____%	____%
<input type="checkbox"/>	65%	35%	NIL	<input type="checkbox"/>	35%	55%	10%	<input type="checkbox"/>	10%	75%	15%	<input type="checkbox"/>	NIL	40%	60%	<input type="checkbox"/>	____%	____%	____%

☐ AGGRESSIVE LIFE CYCLE ALLOCATION SCHEME ☐ PROGRESSIVE LIFE CYCLE ALLOCATION SCHEME

FREQUENCY OF CONTRIBUTION MONTHLY ☐ QUARTERLY ☐ HALF YEARLY ☐ YEARLY ☐ OTHERS ☐

INVESTMENT BY OWN ☐ EMPLOYER ☐

INVESTMENT RS. Front End Load (%) %

PAK RUPPEES (IN WORDS)

MODE OF PAYMENT PLEASE TICK (✓) THE APPROPRIATE BOX

CHEQUE ☐ PAYMENT ORDER ☐ DEMAND DRAFT ☐ BANK TRANSFER ☐

ONLINE TRANSFER ☐ INTERNET BANKING ☐ REMITTANCE ☐

DRAWN ON (BANK AND BRANCH NAME) INSTRUMENT No.



This form should be filled in block capital letters

6. DETAILS OF PRIOR PENSION FUND MANAGER (IF YOU HAVE EVER BEEN A MEMBER OF ANY VPS)

NAME OF PENSION FUND MANAGER										
ADDRESS										
DATE OF JOINING				AMOUNT TRANSFERRED	ENTIRE		OR	RS.		
ARE YOU STILL A MEMBER?	YES		NO		PENSION ACCOUNT NO.					

7. KNOW YOUR CUSTOMER (KYC) FORM

RESIDENTIAL STATUS	Resident Pakistani <input type="checkbox"/> Non - Resident Pakistani <input type="checkbox"/> Resident Foreign National <input type="checkbox"/> Non - Resident Foreign National <input type="checkbox"/>									
PERMANENT RESIDENT IN PAKISTAN (TO BE FILLED BY NICOP HOLDERS ONLY)	Yes <input type="checkbox"/> No <input type="checkbox"/>									
NATIONALITY (OTHER THAN PAKISTAN)	1. NATIONALITY				2. NATIONALITY					
EDUCATION	Under Graduate <input type="checkbox"/> Graduate <input type="checkbox"/> Post Graduate <input type="checkbox"/> Professional Qualification <input type="checkbox"/> Shariah Qualification <input type="checkbox"/> Technical Qualification <input type="checkbox"/> Illiterate <input type="checkbox"/>									
OCCUPATION	Armed Forces Service (A) <input type="checkbox"/> Business/ Self-Employed (B) <input type="checkbox"/> Government Service (C) <input type="checkbox"/> Private Service (D) <input type="checkbox"/> Retired/ Pensioner (E) <input type="checkbox"/> Unemployed/ House wife (F) <input type="checkbox"/>									
NAME AND ADDRESS OF EMPLOYER / EX-EMPLOYER/ BUSINESS / SHOP (TO BE FILLED IN CASE OF A, B, C, D & E)										
DESIGNATION (TO BE FILLED IN CASE OF A,C, D & E)					GRADE/ RANK (TO BE FILLED IN CASE OF A, C, & E)					
NATURE OF BUSINESS (TO BE FILLED IN CASE OF B)										
PROFESSION	Accountant <input type="checkbox"/> Advocate/ Lawyer <input type="checkbox"/> Agriculturist/ Dairy Farmer <input type="checkbox"/> Antique Dealer <input type="checkbox"/> Architect <input type="checkbox"/> Artist <input type="checkbox"/> Auditor <input type="checkbox"/> Banker <input type="checkbox"/> Bureaucrat <input type="checkbox"/> Technician <input type="checkbox"/> Distributor/Agent <input type="checkbox"/> Doctor <input type="checkbox"/> Economist <input type="checkbox"/> Electrician <input type="checkbox"/> Engineer <input type="checkbox"/> Gems Dealer <input type="checkbox"/> Importer/ Exporter <input type="checkbox"/> IT Professional <input type="checkbox"/> Jeweller <input type="checkbox"/> Journalist <input type="checkbox"/> Judge <input type="checkbox"/> Labourer <input type="checkbox"/> Landlord <input type="checkbox"/> Manufacturer <input type="checkbox"/> Soldier <input type="checkbox"/> Student <input type="checkbox"/> Mechanic <input type="checkbox"/> Media Person <input type="checkbox"/> Notary Public <input type="checkbox"/> Nurse <input type="checkbox"/> Transporter <input type="checkbox"/> Wholesaler <input type="checkbox"/> Pharmacist <input type="checkbox"/> Plumber <input type="checkbox"/> Police Officer <input type="checkbox"/> Real Estate Agent <input type="checkbox"/> Scientist <input type="checkbox"/> Real Estate Builder <input type="checkbox"/> Welfare/ Social Worker <input type="checkbox"/> Teacher <input type="checkbox"/> Real Estate Developer <input type="checkbox"/> Retailer/ Shop Keeper <input type="checkbox"/> Partner In Legal / Professional Firm <input type="checkbox"/> Legal/ Financial/ Tax Consultant <input type="checkbox"/> Partner in Business Partnership <input type="checkbox"/> Other <input type="checkbox"/> If "Others" is selected then please specify _____									
SOURCE(S) OF INCOME/ FUNDS (MULTIPLE SELECTIONS CAN BE MADE)	Salary Income <input type="checkbox"/> Business Income <input type="checkbox"/> Rental Income <input type="checkbox"/> Savings <input type="checkbox"/> Stocks/ Investments <input type="checkbox"/> Proceeds from Inheritance <input type="checkbox"/> Agriculture Income <input type="checkbox"/> Monthly Pension <input type="checkbox"/> Gift Proceeds <input type="checkbox"/> Remittances from Third Party <input type="checkbox"/> Sale Proceeds of Property <input type="checkbox"/> Remittances from Family Member <input type="checkbox"/> Sale Proceeds of Furniture, Fixtures & Equipment <input type="checkbox"/> Sale Proceeds of Vehicle <input type="checkbox"/> Retirement Benefits (Provident Fund/ Gratuity,etc.) <input type="checkbox"/> Student receiving Funds from Blood Relative <input type="checkbox"/> Housewife receiving Funds From Husband/ Child/ Blood Relative <input type="checkbox"/>									
ANNUAL INCOME	Below Rs. 1,000,000/- <input type="checkbox"/> From Rs. 1,000,000/- TO RS. 2,500,000/- <input type="checkbox"/> From Rs. 2,500,001/- TO RS. 5,000,000/- <input type="checkbox"/> From Rs. 5,000,001/- TO RS. 7,500,000/- <input type="checkbox"/> From Rs. 7,500,001/- TO RS. 10,000,000/- <input type="checkbox"/> From Rs. 10,000,001/- TO RS. 12,500,000/- <input type="checkbox"/> From Rs. 12,500,001/- TO RS. 15,000,000/- <input type="checkbox"/> From Rs. 15,000,001/- TO RS. 20,000,000/- <input type="checkbox"/> From Rs. 20,000,001/- TO RS. 25,000,000/- <input type="checkbox"/> Above Rs. 25,000,000/- <input type="checkbox"/>									

ARE YOU OR HAVE YOU EVER BEEN ENTRUSTED WITH THE FOLLOWING FUNCTIONS EITHER IN PAKISTAN OR ABROAD?	YES	NO	ARE YOU OR HAVE YOU EVER BEEN THE FAMILY MEMBER OR CLOSE ASSOCIATE OF ANY OF THESE PERSON(S)?	YES	NO
HEAD OF STATE			HEAD OF STATE		
HEAD OF GOVERNMENT			HEAD OF GOVERNMENT		
SENIOR POLITICIAN			SENIOR POLITICIAN		
SENIOR GOVERNMENT OFFICIAL			SENIOR GOVERNMENT OFFICIAL		
SENIOR JUDICIAL OFFICIAL			SENIOR JUDICIAL OFFICIAL		
SENIOR MILITARY OFFICIAL			SENIOR MILITARY OFFICIAL		
SENIOR EXECUTIVE OF STATE OWNED CORPORATIONS			SENIOR EXECUTIVE OF STATE OWNED CORPORATIONS		
IMPORTANT POLITICAL PARTY OFFICIAL			IMPORTANT POLITICAL PARTY OFFICIAL		
SENIOR EXECUTIVE OF INTERNATIONAL ORGANIZATION			SENIOR EXECUTIVE OF INTERNATIONAL ORGANIZATION		
MEMBER OF THE BOARD OF INT'L ORGANIZATION			MEMBER OF THE BOARD OF INT'L ORGANIZATION		

HAS YOUR ACCOUNT EVER BEEN REFUSED BY ANY FINANCIAL INSTITUTION IN PAKISTAN OR ABROAD? YES ☐ NO ☐

IF YES THEN PLEASE EXPLAIN REASON FOR REFUSAL:

DECLARATION: I HEREBY DECLARE THAT THE INFORMATION PROVIDED IN THIS FORM IS CORRECT, COMPLETE AND UP-TO-DATE TO THE BEST OF MY KNOWLEDGE AND BELIEF AND THE DOCUMENTS SUBMITTED ALONG WITH THIS FORM ARE COMPLETE AND VALID IN ALL RESPECTS. I WILL INFORM THE MANAGEMENT COMPANY IF THERE IS ANY CHANGE IN ABOVE-MENTIONED INFORMATION.



8. CUSTOMER DUE DILIGENCE SECTION

(This Section should be filled by Sales Staff / Distributor / Authorized Representative in presence of the Customer)

PURPOSE OF ACCOUNT	Savings for retirement										
DATE OF VERIFICATION OF THE IDENTITY DOCUMENT	<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>			D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				
DATE OF ISSUANCE ON THE IDENTITY DOCUMENT	<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>			D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				
DATE OF EXPIRY ON THE IDENTITY DOCUMENT	<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>			D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				
IS IDENTITY DOCUMENT WITHOUT PHOTOGRAPH?	YES <input type="checkbox"/> NO <input type="checkbox"/> (IF YES, PLEASE OBTAIN PASSPORT SIZE PHOTOGRAPH)										
IS THERE ANY INDICATION THAT CUSTOMER IS PEP OR FAMILY MEMBER OF PEP OR CLOSE ASSOCIATE OF PEP?	YES <input type="checkbox"/> NO <input type="checkbox"/>										
IS THE CUSTOMER LINKED WITH NGO/ NPO/ CHARITABLE TRUST/ SOCIETY/ ASSOCIATION AS DIRECTOR OR TRUSTEE OR MEMBER OF GOVERNING BODY, ETC.?	YES <input type="checkbox"/> NO <input type="checkbox"/>										
IS THE CUSTOMER FOREIGN NATIONAL?	YES <input type="checkbox"/> NO <input type="checkbox"/>										
IS THE CUSTOMER BELONG TO CHAMAN, TORKHAM, TAFTAN OR FATA REGION? [FATA REGION INCLUDES BAJAUR AGENCY, MOHMAND AGENCY, KHYBER AGENCY, ORAKZAI AGENCY, KURRAM AGENCY, NORTH WAZIRISTAN AGENCY, SOUTH WAZIRISTAN AGENCY]	YES <input type="checkbox"/> NO <input type="checkbox"/>										
IS THE CUSTOMER INVOLVED IN ANY OF THE FOLLOWING DESIGNATED NON-FINANCIAL BUSINESSES AND PROFESSION (DNFBPs)?											
REAL ESTATE AGENT, BUILDER OR DEVELOPER	YES <input type="checkbox"/> NO <input type="checkbox"/>	DEALER IN PRECIOUS METALS INCLUDING JEWELLER	YES <input type="checkbox"/> NO <input type="checkbox"/>								
DEALER IN PRECIOUS STONES INCLUDING GEM DEALER	YES <input type="checkbox"/> NO <input type="checkbox"/>	ANTIQUE DEALER	YES <input type="checkbox"/> NO <input type="checkbox"/>								
SELF EMPLOYED LAWYER/ ADVOCATE/ NOTARY	YES <input type="checkbox"/> NO <input type="checkbox"/>	SELF EMPLOYED ACCOUNTANT/ AUDITOR	YES <input type="checkbox"/> NO <input type="checkbox"/>								
SELF EMPLOYED LEGAL/ FINANCIAL/ TAX CONSULTANT	YES <input type="checkbox"/> NO <input type="checkbox"/>	PARTNER IN LEGAL/ PROFESSIONAL FIRM	YES <input type="checkbox"/> NO <input type="checkbox"/>								
IS THE CUSTOMER INVOLVED IN MONEY EXCHANGE BUSINESS, LOW PROFILE INTERNET BASED BUSINESS OR CRYPTO CURRENCY BUSINESS? YES <input type="checkbox"/> NO <input type="checkbox"/>											
EXPECTED TYPE OF COUNTER PARTIES	Self <input type="checkbox"/> Self and Employer <input type="checkbox"/> Employer only <input type="checkbox"/>										
EXPECTED LOCATION OF COUNTER PARTIES	Within Pakistan <input type="checkbox"/> Outside Pakistan <input type="checkbox"/> If "Outside Pakistan" is selected then please specify country _____										
EXPECTED SERVICES WHICH THE CUSTOMER WOULD LIKE TO USE All Services											
EXPECTED DISTRIBUTION/ DELIVERY CHANNEL(S) WHICH THE CUSTOMER WOULD LIKE TO USE	All Channels <input type="checkbox"/> ISAVE Online Portal Only <input type="checkbox"/> Through Sales Agent Only <input type="checkbox"/> Through Distributor Only <input type="checkbox"/> ISAVE Online Portal & Sales Agent <input type="checkbox"/> ISAVE Online Portal & Distributor <input type="checkbox"/>										
NUMBER OF YEARS OF EXPERIENCE OF THE CUSTOMER AS AN EMPLOYEE OR BUSINESSMAN OR PARTNER OR SHOP KEEPER											
ANNUAL INCOME/ ANNUAL SALARY OF THE CUSTOMER											
ESTIMATED NET WORTH OF THE CUSTOMER (Annual income / Annual salary x 20% x No. of years of experience)											
EXPECTED CONTRIBUTION TRANSACTIONS IN A YEAR (RUPEES) (THIS FIGURE SHOULD COMMENSURATE WITH THE ESTIMATED NET WORTH & ANNUAL INCOME OF THE CUSTOMER)	UPTO RS. 500,000/-	<input type="checkbox"/>	UPTO RS. 800,000/-	<input type="checkbox"/>	UPTO RS. 1,000,000/-	<input type="checkbox"/>	UPTO RS. 2,000,000/-	<input type="checkbox"/>			
	UPTO RS. 3,000,000/-	<input type="checkbox"/>	UPTO RS. 4,000,000/-	<input type="checkbox"/>	UPTO RS. 5,000,000/-	<input type="checkbox"/>	UPTO RS. 6,000,000/-	<input type="checkbox"/>			
	UPTO RS. 7,000,000/-	<input type="checkbox"/>	UPTO RS. 8,000,000/-	<input type="checkbox"/>	UPTO RS. 9,000,000/-	<input type="checkbox"/>	UPTO RS. 10,000,000/-	<input type="checkbox"/>			
	ABOVE RS. 10,000,000/-	<input type="checkbox"/>									
EXPECTED NUMBER OF INVESTMENT TRANSACTIONS IN A YEAR	UPTO 5	<input type="checkbox"/>	UPTO 10	<input type="checkbox"/>	UPTO 15	<input type="checkbox"/>	UPTO 20	<input type="checkbox"/>	ABOVE 20	<input type="checkbox"/>	
ANY OTHER INFORMATION ABOUT THE CUSTOMER											
OVERALL ASSESSMENT OF THE CUSTOMER SATISFACTORY <input type="checkbox"/> UNSATISFACTORY <input type="checkbox"/>											
PREPARER:											
NAME OF SALES AGENT / AUTHORIZED REPRESENTATIVE					CODE OF THE SALES AGENT						
SIGNATURE OF THE SALES AGENT / AUTHORIZED REPRESENTATIVE											
REVIEWER:											
NAME OF SALES AGENT / AUTHORIZED REPRESENTATIVE					CODE OF THE SALES AGENT						
SIGNATURE OF THE SALES AGENT / AUTHORIZED REPRESENTATIVE											



9. FOREIGN ACCOUNT TAX COMPLIANCE ACT ("FATCA") SECTION MANDATORY INFORMATION OF PARTICIPANT

Please complete in **BLOCK LETTERS**

Name: _____

Country of Residence: _____

Country of Birth: _____

Please tick (✓) Yes or No for each of the following questions:

- | | | |
|---|-----------------------------|------------------------------|
| 1. Are you a U.S. Resident? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 2. Are you a U.S. Citizen? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 3. Are you holding a U.S. Permanent Resident Card (Green Card)? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 4. Are you registered in the US as a tax payer? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |

Note: If answer to any of the above-mentioned questions is "Yes" then please complete Form W-9 "Request for Taxpayer Identification Number and Certification".

Declaration:

- I hereby confirm that the information provided above is true, accurate and complete;
- Subject to applicable local and foreign laws, I hereby consent for MCBIM, the Trustee of the Voluntary Pension Schemes or any of their affiliates (including without limitation branches) to share my information with domestic and overseas tax authorities, where necessary to establish my tax liability in any jurisdiction;
- Subject to the requirements of domestic or overseas laws, I consent and agree that MCBIM or the Trustee of the Voluntary Pension Schemes may withhold from my account(s) such amounts as may be required according to applicable laws, regulations and directives;
- I hereby undertake not to initiate any proceedings against MCBIM and the Trustee of the Voluntary Pension Schemes in case any amounts are withheld from my account and remitted to the local or foreign authorities/regulators;
- I hereby undertake that I have not granted a Power of Attorney to a person who has an address outside Pakistan to operate the Investor Account (either physically or electronically);
- I hereby undertake that I have no intention to set up Payment Standing Instruction(s) for the banking account(s) and beneficiary account(s) in a country outside Pakistan;
- I hereby undertake to notify MCBIM within thirty (30) calendar days in case of any change in any information whatsoever which I have provided to MCBIM; and
- I further agree and accept that the terms and conditions as contained herein shall form part and parcel of the Account Opening Form and the terms and conditions of the Account Opening Form as well other documentation shall remain in full force and effect.

10. HOW DID YOU HEAR ABOUT US ?

Newspapers / Advertising ☐ Friends / Relatives ☐ Facebook ☐ Instagram ☐ LinkedIn ☐ Youtube ☐ Others _____
(Please Specify)

Principal Applicant Signature/ (Left Hand Thumb
Impression (male)/ Right hand thumb impression (female)

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☒ No Branch Visits





11. DECLARATION AND SIGNATURES

- I, hereby declare that:
- the information provided in this Account Opening Form is correct, complete and up-to-date to the best of my knowledge and belief and the documents submitted along with this Account Opening Form are complete and valid in all respects;
 - I authorize MCB Investment Management Limited ("MCBIM") to use my information and documents for necessary due diligence and verification;
 - I understand that MCBIM may request for additional application form(s)/ document(s) to process my current and future investments in accordance with the requirements of the Anti-Money Laundering Act ("AML Act"), the Securities and Exchange Commission of Pakistan (Anti Money Laundering and Countering Financing of Terrorism) Regulations ("AML Regulations"), Guidelines on Anti-Money Laundering, Countering financing of Terrorism and Proliferation financing ("AML Guidelines") and AML/CFT and CDD/KYC Policies and Procedures of MCBIM. I will ensure to provide these required application form(s)/ document(s) within specified time. I also understand that in order to ensure compliance with aforesaid statutory laws and regulations, MCBIM may reject my investment and/or close my account if the required application form/ document is not provided to MCBIM within specified time or the required application form/ document is not complete and valid in all respects;
 - I have no objection to the Investment Allocation Scheme (mentioned in Section 5) according to which my contributions shall be allocated among the sub-funds of Pension Fund.
 - I understand that MCBIM reserves the right to obtain identity verification services (Biometric/NADRA Verisys) from NADRA to confirm my identification document. I hereby allow MCBIM to confirm my identity using identity verification services of NADRA. I will not hold MCBIM liable or responsible in any manner;
 - I hereby allow MCBIM to verify my bank account number(s) and mobile number(s) through independent sources. I will not hold MCBIM liable or responsible in any manner;
 - I understand that contribution in Pension Fund will be subjected to Zakat deduction if duly executed Zakat Affidavit (CZ-50) is not submitted to MCBIM;
 - I have read and understood the relevant constitutive documents of the Pension Fund in which I am investing. I understand that all contributions in Pension Fund are subject to market risk and the price of the Pension Fund's units may go down resulting in loss of principal investment;
 - I understand that the Offer Price of the Pension Fund's Units may include Front-end Load and could be higher than NAV price of the Units;
 - I am the ultimate beneficiary of the contributions to be invested in the Pension Fund(s) managed by MCBIM. Funds to be invested in the Pension Fund(s) managed by MCBIM are my own funds and the funds beneficially owned by any other person will not be used for making investments in Pension Fund(s) managed by MCBIM;
 - I have been provided with the latest Fund Manager Report (FMR) of the Pension Fund; and
 - I have reviewed the Total Expense Ratio, Management Fee percentage and Sales Load percentages of the Pension Fund as disclosed on the website link: www.mcbfunds.com/statutory-disclosures-for-unit-holders.

PARTICIPANT'S CURRENT SIGNATURE / LEFT HAND THUMB IMPRESSION (MALE)/ RIGHT HAND THUMB IMPRESSION (FEMALE)	PARTICIPANT SIGNATURE AS PER CNIC/ NICOP/ PASSPORT	IN CASE OF INVESTOR HAVING THUMB IMPRESSION OR UNSTABLE/SHAKY/IMMATURE SIGNATURE, ATTESTATION OF GAZETTED OFFICER (BPS-17 AND ABOVE)/ BRANCH MANAGER OF THE BANK/ NOTARY PUBLIC/ AUTHORIZED OFFICER OF THE MCBIM AND TWO ADULT MALE WITNESSES SHALL BE REQUIRED. A PASSPORT SIZE PHOTOGRAPH WILL ALSO BE OBTAINED FROM SUCH INVESTOR.	
		ATTESTATION	WITNESSES (ADULT MALE PERSONS ONLY) NAME: _____ CNIC: _____ SIGNATURE: _____ NAME: _____ CNIC: _____ SIGNATURE: _____

12. INVESTMENT FACILITATOR / DISTRIBUTOR DETAILS (FOR OFFICIAL USE ONLY)

Please write the complete address of the premises where you visited the customer:

HAVE YOU SEEN ORIGINAL CNIC/NICOP OF THE CUSTOMER? YES NO

HAS THE CUSTOMER SIGNED (CNIC/NICOP'S SIGNATURE) IN YOUR PRESENCE? YES NO

IS THERE ANY MATERIAL CHANGE IN THE APPEARANCE OF THE CUSTOMER WHEN COMPARED WITH HIS/HER PICTURE ON CNIC/NICOP?

YES ☐ NO ☐ (If yes, please provide details _____)

I have verified the identity document of the Participant and I have not identified any factor or event which may give rise to suspicion relating to money laundering and/or financing terrorism about the Participant. I will inform the Company if I identify any such factor or event in future relating to the Participant.

DISTRIBUTOR / FACILITATOR NAME		CODE						Distributor's Stamp with date and time
BRANCH NAME		CITY						

13. REGISTRAR DETAILS (FOR OFFICIAL USE ONLY)

Date and Time Stamping	FORM RECEIVED BY	Name and Signature
	DATE, FORM AND ATTACHMENTS VERIFIED BY	Name and Signature
	DATA INPUT BY	Name and Signature

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MCB INVESTMENT MANAGEMENT LIMITED

Head Office: 2nd Floor, Adamjee House, I.I. Chundrigar Road, Karachi

UAN: (+92-21) 111 468 378 (111 INVEST)

URL: www.mcbfunds.com, Email: info@mcbfunds.com

INDIVIDUAL TAX RESIDENCY SELF-CERTIFICATION FORM

- Please complete Parts 1-3 in BLOCK CAPITALS.
- Fields marked with a * are mandatory.
- Fill and complete Part 2 only if Tax Residency is other than USA & Pakistan otherwise mark " Not Applicable (N/A)"

PART 1 – IDENTIFICATION OF INDIVIDUAL ACCOUNT HOLDER

A. NAME OF ACCOUNT HOLDER

FAMILY NAME OR SURNAME(S)*	
TITLE	
FIRST OR GIVEN NAME*	
MIDDLE NAME(S)	

B. CURRENT RESIDENCE ADDRESS

LINE 1 (E.G. HOUSE/APT/SUITE NAME, NUMBER, STREET, if any)*	
LINE 2 (E.G. TOWN/CITY/PROVINCE/COUNTY/STATE)*	
COUNTRY*	
POSTAL CODE/ZIP CODE (if any)*	

C. MAILING ADDRESS (PLEASE ONLY COMPLETE IF DIFFERENT TO THE ADDRESS SHOWN IN SECTION B)

LINE 1 (E.G. HOUSE/APT/SUITE NAME, NUMBER, STREET)	
LINE 2 (E.G. TOWN/CITY/PROVINCE/COUNTY/STATE)	
COUNTRY	
POSTAL CODE/ZIP CODE	

D. DATE OF BIRTH* (DD/MM/YYYY)

<div> <div>d</div> <div>d</div> <div>m</div> <div>m</div> <div>y</div> <div>y</div> <div>y</div> <div>y</div> </div>
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E. PLACE OF BIRTH

TOWN OR CITY OF BIRTH *	
COUNTRY OF BIRTH*	

PART 2 – COUNTRY/JURISDICTION OF RESIDENCE FOR TAX PURPOSES AND RELATED TAXPAYER IDENTIFICATION NUMBER OR EQUIVALENT NUMBER* ("TIN")

Please complete the following table indicating (i) where the Account Holder is tax resident and (ii) the Account Holder's TIN for each country/jurisdiction indicated. Countries/Jurisdictions adopting the wider approach may require that the self- certification include a tax identifying number for each country/jurisdiction of residence (rather than for each Reportable Jurisdiction).

If the Account Holder is tax resident in more than three countries/jurisdictions, please use a separate sheet

If a TIN is unavailable please provide the appropriate reason A, B or C where indicated below:

Reason A - The country/jurisdiction where the Account Holder is resident does not issue TINs to its residents

Reason B - The Account Holder is otherwise unable to obtain a TIN or equivalent number(Please explain why you are unable to obtain a TIN in the below table if you have selected this reason)

Reason C - No TIN is required. (Note. Only select this reason if the domestic law of the relevant jurisdiction does not require the collection of the TIN issued by such jurisdiction)

	COUNTRY/JURISDICTION OF TAX RESIDENCE	TIN	IF NO TIN AVAILABLE ENTER REASON A, B OR C
1			
2			
3			

Please explain in the following boxes why you are unable to obtain a TIN if you selected Reason B above.

1	
2	
3	

PART 3 – DECLARATIONS AND SIGNATURE*

- I understand that the information supplied by me is covered by the full provisions of the terms and conditions governing the Account Holder's relationship with MCBIM and the Collective Investment Schemes and Voluntary Pension Schemes under its management (hereinafter collectively referred to as the "MCBIM Schemes") setting out how MCBIM and MCBIM Schemes may use and share the information supplied by me.
- I acknowledge that the information contained in this form and information regarding the Account Holder and any Reportable Account(s) may be provided to the tax authorities of the country in which this account(s) is/are maintained and exchanged with tax authorities of another country or countries in which the Account Holder may be tax resident pursuant to intergovernmental agreements to exchange financial account information.
- I certify that I am the Account Holder (or am authorised to sign for the Account Holder) of all the account(s) to which this form relates.
- I declare that I have neither asked for, nor received, any advice from MCBIM and MCBIM Schemes in determining my classification as a Reportable Person or otherwise.
- I declare that all statements made in this declaration are, to the best of my knowledge and belief, correct and complete.
- I undertake to advise MCBIM and MCBIM Schemes within 30 days of any change in circumstances which affects the tax residency status of the individual identified in Part 1 of this form or causes the information contained herein to become incorrect or incomplete, and to provide MCBIM with a suitably updated self-certification and Declaration within 30 days of such change in circumstances.

SIGNATURE*	
PRINT NAME*	
DATE*	
NOTE: IF YOU ARE NOT THE ACCOUNT HOLDER PLEASE INDICATE THE CAPACITY IN WHICH YOU ARE SIGNING THE FORM. IF SIGNING UNDER A POWER OF ATTORNEY PLEASE ALSO ATTACH A CERTIFIED COPY OF THE POWER OF ATTORNEY	
CAPACITY*	

Health Questionnaire for Group Family Takaful Plan

Applicable only for MCB Funds VPS Account Holders

Existing MCB Funds Investors ☐ Yes, Master Relationship No. _____ ☐ No

Name of Company: MCB Investment Management Limited. Group Policy No. _____

Name of Investor _____ Date of Birth: _____

Present Occupation: _____ C.N.I.C NO: _____

TEL: (RES) _____ TEL: (OFFICE) _____ TEL: (CELL) _____

Height _____ Weight _____ Gain or Loss past Year: _____

Beneficiary/Nominee Name (Beneficiary/Nominee can only be a blood relation): _____

Beneficiary/Nominee CNIC: _____ Relationship with Investor: _____

Personal Physician (Name and Address): _____

Takaful sum covered/Total invested value: _____

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1) Have you ever had or been diagnosed with any of the following: | | |
| a) High blood pressure, chest pain, stroke or any heart or circulatory trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Enlarged glands or any form of cancer, tumour or disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Diabetes mellitus or any disorder of the kidneys, liver or bladder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Any disorder of the stomach or bowels? | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Any disorder of the joints or vertebral column? | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Shortness of breath, asthma, bronchitis or any disorder of the lungs? | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Epilepsy, fits or fainting attacks, frequent headaches, nervous breakdown? | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Any illness, injury or disability not mentioned above? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, please give details (date, duration, treatment, name/address of physicians) on the back signed by yourself. | | |
| 2) a) Are you presently taking medication of any kind? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Have you ever been counselled or medically advised or treated in connection with an H.I.V. infection, AIDS or any sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, please give full particulars on the back signed by yourself | | |
| 3) Have any of your natural parents, brothers, sisters died or suffered before age 60 from diabetes mellitus, heart diseases, cancer, stroke, multiple sclerosis, mental or neurological disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, please give details (age if living, present state of health, age/cause of death) on the back signed by yourself. | | |
| 4) a) Have you had any life assurance or accidental death, disability, critical illness covers in force? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Have you applied for any other cover with another company at the time being? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Have any application for life, accidental death, disability, critical illness covers ever been declined or modified in plan or rate? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, please give details (sum assured, duration, reason for loading, policy interest) on the back signed by yourself. | | |
| 5) Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |

If so, please state your normal daily consumption of cigarettes, cigarillos, cigars or pipe:

6) Do you drink Alcohol? ☐ ☐

If so, what is your normal weekly consumption of alcohol (please state also whether beer, wine or spirits):

7) Have you ever taken drugs other than those prescribed by a doctor? ☐ ☐

If so, please give details (date, duration, type of drugs) on the back signed by yourself.

8) Do you participate or intend to participate in any hazardous pursuits or activities (e.g. diving, motor racing, aviation)? ☐ ☐

If so, please give details (e.g. diving depth, type of vehicle, type of aircraft) on the back signed by yourself.

9) Do you perform any hazardous occupational activities or foreign travels, stays? ☐ ☐

If so, please give details (e.g. exact type of hazard, name/region of the country) on the back signed by yourself.

I hereby declare that the foregoing statements and answers are full, complete and true. I agree that they shall be the basis of the issuance of coverage for me under the Group Family Takaful Plan, and Adamjee Life Assurance Co Ltd - Window Takaful Operations shall not be liable for any claim on account of illness, injury, or death, the cause of which was known prior to approval of my request for coverage and withheld or concealed in the above statements.

I authorize any physician, nurse, hospital official or employee to disclose to Adamjee Life Assurance Co. Ltd – Window Takaful Operations any and all information regarding my medical history.

Place

Date

Signature of Investor

COVID QUESTIONNAIRE FORM

PLEASE ANSWER FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1 - Do you currently have or have you had any of the following symptoms in the past 14 days?

- ☐ Fever
- ☐ Sore throat
- ☐ Dry cough
- ☐ Myalgia/arthralgia (generalized body ache/ pain in joint areas)
- ☐ Headache
- ☐ Shortness of breath
- ☐ Fatigue
- ☐ Dysgeusia (distortion of the sense of taste)
- ☐ Anosmia (loss of the sense of smell)

If yes, please provide further details i.e. dates, duration, treatment, results of investigations (if any), name and address of treating doctor/clinic/hospital.

.....

2 - Have you been tested for Covid-19?

Yes

No

If Yes: Date of the test:

(Please share the last COVID-19 PCR report if COVID positive within 3 months)

Result of the test:

- ☐ **Covid-19 positive**
- ☐ **Covid-19 negative**

Have you made a complete recovery with no sequelae?

Yes

No

3- Within the past 14 days have you had any contact with someone confirmed as infected with the virus?

Yes

No

4- Have you been issued any notice or directive to self-quarantine or stay home (excluding as part of altered employment arrangement)?

Yes

No

5- Are you currently residing outside your usual country of residence or have you returned to your usual country of residence within the last 4 weeks?

Yes No

If yes, please provide information: Country / City / Departure Date / Arrived Date / Planned return date.

.....

6- In the next three months, do you intend to travel outside your usual country of residence?

Yes No

If yes, please provide information: Country / City / Date of Travel / Intended Duration

.....

Documents checklist:

- | | | |
|---|------------------------------|-----------------------------|
| • COVID - 19 Questionnaire attached: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Investor CNIC copy attached: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| • Beneficiary/Nominee CNIC copy attached: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

I hereby declare that the foregoing statements and answers are true and that no fact has been withheld. I agree that they shall constitute part of my application for group family takaful coverage. I understand and accept that failure to disclose a fact or giving false information may invalidate the contract or may result in non-payment of a claim.

Date:

Place:

 Signature of Investor