



TO: Cooper Grace Ward  
Level 21, 400 George Street, Brisbane 4000  
GPO Box 834, Brisbane 4001

F 61 7 3231 8402  
T 61 7 3231 2402  
E applications@cgw.com.au  
W www.cgw.com.au

**1. Applicant details**

Firm name:					
Contact name:					
Telephone:		Fax:			
Email address:					
Postal address:					
Suburb/city:		State:		Postcode:	
Street address:					
Suburb/city:		State:		Postcode:	

**2. Superannuation fund name**

Name of SMSF	
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**3. Trustee details**

Full name of trustee/s (list all):	
ACN (if corporate trustee):	
Directors: (list all if corporate trustee)	

**4. Member/pensioner details** (Please complete a separate application form for each member starting a pension)

Full name:	
Residential address:	
Date of birth:	
Tax file number:	

**5. Pension details**

Pension start date:	
Accumulation account balance at start date:	\$ _____
Pension amount:	<input type="checkbox"/> Entire balance <input type="checkbox"/> Other: \$ _____
Pension components:	Taxable component: \$ _____ Tax-free component: \$ _____
Transition to retirement income stream?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Condition of release satisfied:	<input type="checkbox"/> over age 65
	<input type="checkbox"/> reached preservation age and wish to commence a transition to retirement pension

	<input type="checkbox"/> age 55 or over, but not yet 65 years of age, have ceased gainful employment and never intend to again become gainfully employed, either on a full-time or part-time basis.
	<input type="checkbox"/> age 60 or over, but not yet 65 years of age and ceased an arrangement of gainful employment <b>after</b> turning 60.
	<input type="checkbox"/> other (please specify): _____
Payment frequency:	<input type="checkbox"/> weekly <input type="checkbox"/> fortnightly <input type="checkbox"/> monthly <input type="checkbox"/> quarterly <input type="checkbox"/> annually <input type="checkbox"/> other (please specify) _____
Payment amount:	<input type="checkbox"/> minimum <input type="checkbox"/> maximum (transition to retirement only) <input type="checkbox"/> other: \$ _____ per _____
Will the tax-free threshold be claimed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Will any assets be segregated to pay this pension?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please list all: _____

### 6. Reversionary beneficiary

Is the pension reversionary?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reversionary beneficiary:	Full name:	_____
	Relationship to member/pensioner:	_____
	Residential Address:	_____
	Date of birth:	_____
	Tax file number:	_____

### ADDITIONAL OPTIONS

<b>Binding nomination:</b> (\$275 incl. GST each)	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please complete the binding nomination application form.
<b>SMSF trust deed update:</b> (\$495 incl. GST)	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please complete the SMSF trust deed update application form.
<b>Estate planning advice or meeting:</b> (Quote on application)	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, we will call you to discuss your questions or arrange a time for a meeting to discuss your estate planning.

### We confirm we:

- are being asked to just prepare the document;
- are not being retained to provide any advice in relation to the appropriateness;
- have not been provided any information about and are not required to investigate whether this document works with the client's estate planning strategy; and
- have not and are not required to review the documentation for any pension and how those terms work with the binding nomination.

**Please send this form to Cooper Grace Ward with the following documents:**

- trust deed;
- deeds of variation (including any deeds or minutes changing the trustee); and
- most recent completed financials showing assets (where you have elected to segregate).

Dated the \_\_\_\_\_ day of \_\_\_\_\_ 2021

\_\_\_\_\_  
 Signature of applicant

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**OPTIONAL – Payment by credit card**

*If you would like to pay by credit card, please complete the section below. If you would prefer we disburse our costs to your next account, please leave this section blank.*

Card type:	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Visa	
Card number:		Expiry date (mm/yy):	/
Name of cardholder:		Amount:	
Signature of cardholder:	_____		
Date:	/ /	Contact phone no.:	

**Please print this form, review and sign it, and fax it to 61 7 3231 8402 or email to [applications@cgw.com.au](mailto:applications@cgw.com.au)**