COOPER GRACE WARD
LAWYERS

Application for binding death benefit nomination

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:					
Street address:					
Suburb/City:		State:		Postcode:	

2. Name of superannuation fund

Name::	

3. Name of member

Full name:	
Residential address:	
Date of birth:	
Is the member drawing a pension	☐ YES ☐ NO
If YES, is the pension reversionary?	☐ YES ☐ NO
If YES, who is it reversionary to?	

4. Name of person the member is nominating

Full name:	
Relationship to member:	
If spouse, are they to receive the benefit as a continuation of the member's income stream?	☐ YES ☐ NO

5. Does the member want to nominate a fallback? For example: their children or their estate

Full name:	
Relationship to the member:	
Percentage amount of the benefit:	%
Full name:	
Relationship to the member:	
Percentage amount of the benefit:	%

6. Please send this form to Cooper Grace Ward **with a copy of the trust deed and any amending deeds**.

   We need to review to the trust deed to ensure it allows for binding death benefit nominations. The trust deed for the fund may require amendment, we will let you know before we do this and the fee.

7. We confirm we:

   (a) are being asked to just prepare the document;

   (b) are not being retained to provide any advice in relation to the appropriateness;

   (c) 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

   (d) have not and are not required to review the documentation for any pension and how those terms work with the binding death benefit nomination.

Dated

____
Signature of applicant

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:	☐ MasterCard ☐ Visa		
Card number:		Expiry date (mm/yy):	/
Name of cardholder:		Amount:	
Signature of cardholder:	______________________________		
Date:	/ /	Contact phone no.:	