

Office Use  
Plan ID **SZ**



**AXA Business Superannuation  
PARTICIPATION AGREEMENT**

**TO: New Zealand Permanent Trustees Limited ("Trustee") AND  
AXA Wealth Management Limited ("Administration Manager")**

Subject to the Administration Manager's approval, by entry into this Participation Agreement the Participating Employer establishes a Plan under AXA Business Superannuation, a division of the Superannuation Master Trust ("Scheme").

**PLEASE PRINT CLEARLY IN BLOCK LETTERS**

**PARTICIPATING EMPLOYER**

Full name of Participating Employer

Plan name (if different to above)

Associated Employers (if any)

**PLAN CONTACT NAME**

Name  Position/Title

Telephone  Fax

Email

Postal address

Postcode  Number of employees

**PLAN AUTHORISED OFFICERS**

The following are authorised on behalf of the Participating Employer for the purpose of supplying to the Administration Manager or the Trustee any notice, comment or information required to facilitate the administration of the Plan. If an Authorised Officer is a Member under the Plan, two Authorised Officers are required. Any notice to the Trustee or the Administration Manager directly affecting the membership of an Authorised Officer must be given by the other Authorised Officer.

1. Full Name

Position / Title  Signature

2. Full Name

Position / Title  Signature

**PLAN DETAILS**

**Type of Plan**  Exempt employer plan. Relevant contributions and benefits will be subject to Clause 10.2 of the Trust Deed for the Scheme.

Employer IRD number

**Important notes:**

1. Every new permanent employee joining service from 1 July 2007 must be eligible to join the Plan.
  2. Member plus employer contributions must be a minimum of 4% of the member's gross annual base salary or wages ('the Minimum Amount').
  3. Any portion of the Minimum Amount that is made from employer contributions must vest to the member by the end of five years membership.
- Neither of these

**Locked-In Status**  Locked-in  Unlocked

**Nominated Members** Does the Plan allow Nominated Members?  Yes  No

**Fees** (To be agreed with the adviser to the Plan and subject to the requirements of the applicable legislation in force at the time this Participation Agreement is entered into)

Plan Fee  % Contributions Fee  %

**Annual Review Date** (The month annual statements will be produced.)

The annual review date for the Plan will be the first day of  (Please indicate month.)

**Investment of Plan Reserve Account**

Please specify the investment portfolio(s) in which the Plan's Reserve Account is to be invested (if more than one investment portfolio is specified, please also specify proportions).

**Internet Access**

Do you want to register for online access to your company's superannuation scheme? (please tick)  Yes  No

**BILLING AND PAYMENTS** (Please refer to Help Cards for more information.)

1. Payroll/Reporting centre description (e.g. CHCH staff, AUUCK staff)   
Payroll/Reporting centre contact name  Position   
Telephone  Fax  Email   
Postal address  Postcode

2. Payroll/Reporting centre description (e.g. CHCH staff, AUUCK staff)   
Payroll/Reporting centre contact name  Position   
Telephone  Fax  Email   
Postal address  Postcode

Billing format(s) to be agreed with the Administration Manager.

If there are more than two Payroll/Reporting Centres please continue on a separate sheet.

**INSURANCE** (If applicable)

(Please note: for an exempt employer plan, the Minimum Amount cannot be used to meet insurance premiums under the Plan).

No Insurance

Insurance for any particular Member is subject to acceptance by the Insurer.

In order for rates to be determined please complete the Request for Group Insurance Rates and Underwriting Terms form.

**Insurance category 1** (Please indicate the category of Members to which this insurance alternative will apply.)

1<sup>st</sup> Category Description   
(e.g. all Members/ executives/office staff etc)

**Insurance type** (Please tick one.)

Death  Trauma  Death and Trauma  
 Death or Total and Permanent Disablement  Death or Total and Permanent Disablement and Trauma

**Insurance basis** (Please tick one and complete details.)

Fixed amount \$   Fixed amount + CPI \$   
 Multiple of Salary  x Salary  Sliding scale  % of Salary x term to retirement age

**Insurance category 2** (If applicable. Please indicate the category of Members to which this insurance alternative will apply.)

2<sup>nd</sup> Category Description

**Insurance type** (Please tick one.)

- Death  Trauma  Death and Trauma  
 Death or Total and Permanent Disablement  Death or Total and Permanent Disablement and Trauma

**Insurance basis** (Please tick one and complete details.)

- Fixed amount \$   Fixed amount + CPI \$   
 Multiple of Salary  x Salary  Sliding scale  % of Salary x term to retirement age

Additional categories of insurance can be added by completing an Appendix to Participation Agreement.

**IMPORTANT INFORMATION**

- 1 The Participating Employer agrees to be bound by the terms and conditions of the Trust Deed governing the Scheme and the Member Application in respect of any Member under the Plan.
- 2 The Participating Employer agrees to do all things necessary and supply such information as the Administration Manager or the Trustee may require for the administration of the Plan.
- 3 Pursuant to the Contracts (Privity) Act 1982, this Participation Agreement is made for the benefit of, and is intended to be enforceable by, the Trustee, the Administration Manager and any Member under the Plan.

- This plan is to be an exempt employer plan and the application form is attached.

Dated this  day of  20

**COMPANY**

If the Participating Employer is a company, complete this section. Otherwise complete the following section.

**Signed by the Participating Employer by:**

Signature of director   
Signature of director

**PARTNERSHIP, SOLE TRADER OR OTHER**

**Signed by the Participating Employer by:**

Authorised signatory   
Name  Position

In the presence of

Signature   
Witness Name   
Witness Address

**ADVISER USE ONLY**

Adviser name

Adviser %

Adviser ID:

Adviser name

Adviser %

Adviser ID:

ABS provides three Annual Review formats. The "Standard" format shown below applies automatically unless you select one of the "Optional" formats.

Please tick only if you want to specify one of the Optional Review Formats. Otherwise leave blank.

- Optional Format      All fees and insurance premiums individually specified.
- Optional Format      Aggregate of total earnings and fee deductions.
- Standard Format      Insurance premiums and the sum of all other fees. This option applies automatically unless you nominate one of the Optional Formats.

**FORWARD COMMUTED COMMISSION (FCC)**

Forward Committed Commission       Yes       No      (Please tick)

If yes, please tick the responsibility period to apply:

- 1 year       2 years       3 years       4 years       5 years

NB: Clawback applies if contributions cease or decrease within this period.