

Application for full commutation of benefits



Please complete this form using BLOCK CAPITALS

All fields highlighted with an asterisk (*) are mandatory

Member Details

Title _____ Surname* _____

First names _____

National Insurance number* _____ Member number* _____

Data Protection

Universities Superannuation Scheme Limited (the trustee) takes its obligations under the General Data Protection Regulation (GDPR) seriously and has appropriate procedures in place to ensure your personal data, special category personal data e.g. medical or health information, and your rights are protected. The information provided on this form will only be used by the trustee for the purpose of assessing and administering an application for full commutation. In the course of processing the information for this purpose, we may disclose your personal data, including special category personal data, to our appointed medical advisers. Find out more about how we collect and process your personal data, protect your privacy, and how you can contact our data protection officer, by visiting uss.co.uk/privacy-notice. For a glossary of our terms please see more information on our [important terms](#) page.

Member declaration

I confirm that I wish to apply for full commutation of pension from the scheme on grounds of serious ill health and to support my application I confirm the following:

- I have read and understood the information contained in the full commutation factsheet and I meet the criteria set out in the Rules and legislation for full commutation on grounds of serious ill health. (A copy of the commutation factsheet is available on our website, via your pensions contact at your employer, or directly from USS).
- The lump sum payable upon full commutation will be used in such a way that there will be suitable provision for my needs, and those of my dependants, if the opinions on life expectancy expressed by the medical advisers should prove to be unduly pessimistic.
- I am aware of the alternatives to commuting the benefits to a lump sum and I acknowledge that the trustee has recommended that I take financial advice before making an application for full commutation and I have taken such advice as I consider appropriate in the circumstances.
- I understand by signing this declaration that the trustee can take this application into account but is not legally bound to approve full commutation of pension on grounds of serious ill health. I acknowledge that if my application is approved, payment of benefits will be subject to completion of any forms or other steps required by the trustee.
- I understand that in the unfortunate event of a member's death before the trustee's medical advisers have given an opinion that life expectancy is less than 12 months, then the full commutation may not be able to proceed.
- By signing this declaration I provide my consent to the trustee reviewing and processing the necessary medical information including providing it to the USS appointed medical advisers in connection with this application.

Signed _____ Date _____

This application must be signed by the member or their attorney. If the application is signed by an attorney, a certified copy of the power of attorney must be submitted with the application.

Please return the completed form to :

*** if you are an active or flexibly retired member** - to your employer's pensions contact. It is your employer's responsibility to submit your application to the trustee; or

*** if you are a deferred member** - to the trustee.
