



AMIDEX FUNDS, INC. NEW INDIVIDUAL RETIREMENT ACCOUNT APPLICATION

Please retain a copy for your records. If you have questions about completing this form, call 888-876 3566. In compliance with the USA PATRIOT Act, all mutual funds are required to obtain the following information for all registered owners and all authorized individuals: full name, date of birth, Social Security number, and permanent street address. This information will be used to verify your true identity. We will return your application if any of this information is missing, and we may request additional information from you for verification purposes. In the rare event that we are unable to verify your identity, the Fund reserves the right to redeem your account as an age-appropriate distribution at the current day's net asset value.

1. Whose IRA is This? US Bank, Custodian for the IRA of:

Full Name _____ Social Security Number _____
 _____ / _____ / _____
 Mailing Address (If mailing address above is a post office, a street address is also required by the USA Patriot Act) _____
 _____ / _____ / _____
 Date of Birth (required) _____
 _____ - _____
 City State Zip Daytime Telephone _____
 Dealers and Financial Planners check here to request duplicate statements and complete information at the back of the form. _____
 Email Address _____

2. What Type of IRA is it?

TRADITIONAL IRA		ROTH IRA	SEP IRA
<input type="checkbox"/> Individual	<input type="checkbox"/> Direct Rollover from 403(b)	<input type="checkbox"/> Individual	<input type="checkbox"/> Individual
<input type="checkbox"/> Transfer †	<input type="checkbox"/> Direct Rollover from 401(k)	<input type="checkbox"/> Transfer from ROTH IRA to ROTH IRA *†	<input type="checkbox"/> Transfer †
<input type="checkbox"/> Rollover	<input type="checkbox"/> Direct Rollover	<input type="checkbox"/> Rollover from ROTH IRA to ROTH IRA *	<input type="checkbox"/> Rollover
		* Date exiting ROTH IRA was originally opened ____ / ____ / ____	

† Complete transfer request form

3. Who will be beneficiaries on this account?

PRIMARY BENEFICIARY

First Name _____	Last _____	Relationship _____	First Name _____	Last _____	Relationship _____
Mailing Address (Required by the USA Patriot Act.) _____			Mailing Address (Required by the USA Patriot Act.) _____		
City _____	State _____	Zip _____	City _____	State _____	Zip _____
____ - ____ - ____ - ____	____ / ____ / ____		____ - ____ - ____ - ____	____ / ____ / ____	
Social Security Number _____	Date of Birth _____		Social Security Number _____	Date of Birth _____	

SPOUSAL CONSENT: If you are married and you name someone other than your spouse as primary beneficiary and reside in a community or marital property state, including AZ, CA, ID, LA, NV, NM, TX, WA, or WI, then your spouse must sign below.

X _____
 Signature of Spouse _____ / ____ / ____
 Date _____

4. Which AMIDEX Fund(s) Do You Wish to Invest In?

Please list Fund(s)	(Indicate Tax Year if applicable) 200__ 200__	IRA Transfer (Complete Transfer Request Form)	Rollover (Enclose Check)
AMIDEX35 Israel Mutual Fund	\$ _____ \$ _____	% OR \$ _____	% OR \$ _____
AMIDEX Cancer Innovations & Healthcare Fund	\$ _____ \$ _____	% OR \$ _____	% OR \$ _____

Minimum initial investment is \$500 for IRAs, \$250 for subsequent investments. Annual Maintenance Fee: \$12.00 per taxpayer will be deducted from the account at year-end.

5. Automatic Investment Plan. A voided check must be attached.

Bank Name _____
 Bank Address _____
 _____ City _____ State _____ Zip _____
 Bank Transit/ABA No. _____ (nine digits) My Account No. _____
 Select Monthly deposit (minimum \$100) Quarterly deposit (minimum \$200); and day:
 1st of the month (or next business day) 15th of the month (or next business day) \$ _____ Amount of Deposit

ACH is a convenient way to purchase shares automatically or at your discretion. AMIDEX Funds, Inc. provides a convenient way to transfer money from your bank account to your AMIDEX account. Please note savings accounts are not eligible for ACH. We will send confirmation of your AMIDEX Mutual Fund ACH services; please wait 3 weeks after receiving the notice before using the service.



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6. Dividend and Capital Gains Payment Options

(If no choice is made, dividends and capital gains will be reinvested.)

Income Dividends reinvested paid in cash

Capital Gains Distributions reinvested paid in cash

7. Telephone/Mail Redemptions

You may redeem shares from your account simply by calling Matrix Group Inc. Please check the box below to establish the Telephone Mail Redemption Service.

I want Telephone/Mail Redemption Service.

8. Acceptance by Custodian

Our organization agrees to serve as the new Custodian for the IRA account of the above-named individual. As Custodian: we agree to accept assets being transferred.

New Custodian: US Bank
Matrix Capital Group, Inc., Agent

Authorized Signature of Accepting Organization

____/____/_____
Date

9. Signature

By signing the application establishing an IRA, the undersigned: (1) establishes an Individual Retirement Account pursuant to the Employee Retirement Income Security Act of 1974 and in accordance with all the terms of the Custodial Agreement on Form 5305-A or 5305-RA; (2) appoints US Bank or its successors, as Custodian of the Account, (3) states that he or she has received, read, accepts and specifically incorporates herein the Custodial Agreement on Form 5305-A or 5305-RA and the Disclosure Statement, (4) agrees to promptly give instructions to the Custodian necessary to enable the Custodian to carry out its duties under the Custodial Agreement, (5) acknowledges receipt of the current Prospectus of the Fund(s). Under penalties of perjury, I certify that the number shown on this form is my correct Social Security Number, and that I have not been notified by the IRS that I am subject to back-up withholding.

SIGNATURE

DATE

FOR BROKER USE ONLY

Broker/Dealer or Investment Advisor Authorization

The underlined Dealer/Advisor agrees to all applicable provisions on this application, and guarantees the genuineness of the signature on the Application. If the shareholder(s) do not sign the Application, the dealer warrants that this Agreement is complete in accordance with the shareholder's instructions and agrees to indemnify the Fund, Advisor, Distributor and The Matrix Capital Group, Inc. for any loss or liability from acting upon such instructions.

Representative/Advisor's Name _____ Rep's Number _____

Rep's Phone (____) - ____ - _____ Rep's Fax (____) - ____ - _____ Rep's Email Address _____

Firm's Name _____ Branch Number _____

Firm's Address _____
City State Zip

Representative/Advisor's Signature _____
DATE

For more information, please call 888-876 3566

Please mail complete application to:

**AMIDEX Funds, Inc.
c/o Matrix Group Inc.
630-A Fitzwatertown Road, 2nd Floor
Willow Grove, PA 19090**