INCOME PROTECTION REVIEW FORM

SUPER SA
contributing to your future

Please complete this form in BLOCK LETTERS using a BLACK PEN and return all the signed ORIGINAL forms to Super SA.

Personal Details

Account ID

☐ Mr ☐ Ms ☐ Miss ☐ Mrs ☐ Dr ☐ Prof

Surname

Given name(s)

Residential address

Postcode

Postal address (if different from above)

Postcode

Date of birth / /

Email*

Telephone* (M)

(W)

(H)

*By providing your email address and/or telephone number(s) you are agreeing to receive, from Super SA, or an organisation on behalf of Super SA, marketing communications including newsletters, announcement, invitations or surveys. You may opt out of these marketing communications at any time by updating your communication preferences in our online member portal or by contacting Super SA. If you opt out of marketing communications, you will still receive any important account information from us.

Contact us

Address
Ground floor,
151 Pirie Street
Adelaide SA 5000
(Enter from Pulteney Street)

Postal
GPO Box 48, Adelaide, SA 5001

Call
(08) 8207 2094
1300 369 315 (for regional callers)

Email
supersa@sa.gov.au

Website
supersa.sa.gov.au

Part A: Member Statement

To be completed by the member

Have you received any pay for any work performed or any paid leave or otherwise in the last three to six months?

☐ Yes ☐ No

If yes, please give details

Have you received, applied for, do you intend to apply for or are you entitled to receive Worker's Compensation or any other payments?

☐ Yes ☐ No

If yes, please give details including date of application, date payments commenced and Injury manager or case manager contact details.

Have you received, applied for, do you intend to apply for, or are you entitled to receive, any other entitlements (eg TVSP)?

☐ Yes ☐ No

If yes, please give details including date of application, date payments commenced and case manager contact details.

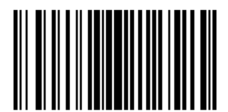
Have you received, applied for, do you intend to apply for, or are you entitled to receive any leave entitlements?

☐ Yes ☐ No

If yes, please give details

Please complete and sign the Member Declaration on page 2.

Part B: Medical Report is on pages 3 to 5.
This section is to be completed by your medical practitioner.



INCOME PROTECTION REVIEW FORM

Part A: Member Statement

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Member Declaration

Is any further medical evidence/information attached? ☐ Yes ☐ No

- I declare that all the information supplied by me is true and correct.
- I understand that it is an offence to provide false or misleading information.
- I authorise any hospital, doctor or other person who has treated or examined me to provide Super SA with any further information or medical reports on my illness or injury, medical history, consultations, prescriptions or treatment.
- I authorise Super SA to gain access to any Return to Work information including medical reports or any other similar information (if applicable).
- Super SA may provide a copy of this authority to the third party to obtain necessary information.
- I also authorise Super SA to provide this information to any other medical practitioner for the purpose of assessing my claim.
- I understand that Super SA and its medical adviser(s) will use this information for the purpose of considering my application.
- I understand that Super SA will obtain information from my employer and may provide my medical details to my employer, which it is authorised to do so for the purpose of assessing my claim under the relevant Act and Regulations.
- I understand I will have to pay the cost of providing any medical evidence to support my review.

Signature: ✘ **Date:** / /

Part B: Medical Report is on pages 3 to 5.
This section is to be completed by your medical practitioner.

INCOME PROTECTION REVIEW FORM

Part B: Medical Report (To be completed by your **medical practitioner**)

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Please complete this form in BLOCK LETTERS using a BLACK PEN and return all the signed ORIGINAL forms to Super SA.

1. **Name of claimant** **Date of Birth** / /
2. From what date have you been the claimant's treating doctor? / /
3. On what date did you first see the claimant in connection with his/her condition(s)? / /
4. Does the claimant have an appointment to see you again? ☐ Yes ☐ No If yes, please give date / /
5. Please complete the following in respect of the claimant's medical condition(s)

Medical Condition	Date first suffered
1.	/ /
2.	/ /
3.	/ /
4.	/ /

How do these conditions affect the claimant's ability to perform work duties?

Provide details of investigations or tests performed (Please attach results).

Provide details of treatments, current and trialed.

What is the prognosis, including the likely outcome of any treatments?

(If you require more space, please attach a separate sheet.)

6. Is the claimant's condition terminal? ☐ Yes ☐ No

   If yes, is the condition likely to be terminal within: ☐ 12-24 months ☐ 2-5 years ☐ 5-10 years

INCOME PROTECTION REVIEW FORM

Part B: Medical Report (To be completed by your **medical practitioner**)

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7. Any other comments which you believe may be relevant in the assessment of this claim.

Based on your professional medical opinion:

8. Is the claimant fit for his/her **usual work**?

> Full time (>30 hrs) ☐ Yes ☐ No

> Part time (15-30 hrs) ☐ Yes ☐ No

Nature of work – please indicate ☐ Light ☐ Moderate ☐ Heavy ☐ Other

Please provide details:

9. Is the claimant fit for **any other alternative work** including sedentary work?

> Full time (>30 hrs) ☐ Yes ☐ No

> Part time (15-30 hrs) ☐ Yes ☐ No

Nature of work – please indicate ☐ Light ☐ Moderate ☐ Heavy ☐ Other

Please provide details:

10. If the claimant is currently not fit for his/her usual work or alternative work, please estimate when, in your opinion, the member is likely to be able to return to **any** form of work.

11. Please indicate if there is any type of work the claimant may be able to perform in the future. If so, what medical treatment, rehabilitation, training or other steps may be required?

12. If it is premature to express an opinion about when the claimant could return to work, please provide an estimate as to when an opinion could be expressed.

13. To assist with the assessment of this review, please provide copies of the following (if applicable)

- List of Current Medications ☐
- Specialist Reports ☐
- Test Results (eg blood tests) ☐
- Health Care Plans ☐
- X-Ray/MRI/Radiological Reports ☐
- Biopsy Reports ☐
- Orthopaedic Assessments ☐
- Hospital or Separation Reports ☐
- Return to Work Reports ☐

14. Is any further medical evidence/information attached? ☐ Yes ☐ No

Part B: Medical Report (To be completed by your **medical practitioner**)

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Declaration **(By medical practitioner completing this form)**

- I hereby certify that I have personally attended the member and that all the information supplied by me on this form is true and correct.
- I understand that Super SA and its medical adviser(s) will use this information and may provide copies of this report to the claimant or to any medical specialist from whom it seeks an independent report, or to any other person deemed necessary to assist in the assessment of this claim.

Name

Name of Practice

Address

Postcode

Telephone

Registration and/or provider number

Qualifications

Medical Specialty

Signature ✘ **Date** / /