Form > SA Ambulance Service Superannuation Scheme

CLAIM FOR DISABLEMENT ENTITLEMENTS REVIEW

SUPER SA
contributing to your future

Please complete all the details on this form and return it to Super SA

1. Personal Details

Super ID

☐ Mr ☐ Ms ☐ Miss ☐ Mrs ☐ Dr ☐ Prof

Surname

Given name(s)

Address

Postcode Date of birth / /

Email*

Telephone* (W)

(H)

(M)

Employee no

OFFICE ONLY

Membership class ☐ AD ☐ EL ☐ EM

Part A: Declaration

Is any further medical evidence/information attached?

☐ Yes ☐ No

- I declare that all the information supplied by me is true and correct.
- 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 Workcover medical report (if applicable).
- I also authorise Super SA to provide this information to any other medical practitioner who may be assisting with assessment of my claim. A photocopy or facsimile of this authorisation is as valid as the original.
- I understand that Super SA and its medical adviser(s) will use this information for the purpose of considering my application.

Signature Date / /

Part B: Medical Report on pages 2, 3 and 4. This section is to be completed by your medical practioner.

Disclaimer: If all sections are not completed the processing of your claim may be delayed.

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 or 1300 369 315 (for regional callers)

Email
supersa@sa.gov.au

Website
www.supersa.sa.gov.au

*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, announcements, invitations or surveys. You may opt out of these marketing communications at any time by contacting Super SA. If you opt out of marketing communications, you will still receive any important account information from us.

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Part B: Medical Report

To be completed by your medical practioner

From what date have you been the member's treating doctor?

On what date did you first see the member in connection with his/her condition(s)?

Does the member have an appointment to see you again? ☐ Yes ☐ No
If YES, please give date / /

Please complete the following in respect of the member's medical condition(s):

Diagnosis	Functional consequences

Please estimate the member's overall level of capacity for work _____%.
(Note: 100% capacity means the member is completely fit for work)

Based on your professional medical opinion:

a) Is the member fit for his/her **usual** work?

Full-time (>30 hrs) ☐ Yes ☐ No
If YES, nature of work - please indicate ☐ Light ☐ Moderate ☐ Heavy

Part-time (15-30 hrs) ☐ Yes ☐ No
If YES, nature of work - please indicate ☐ Light ☐ Moderate ☐ Heavy

b) Is the member fit for **any** other alternative work?

Full-time (>30 hrs) ☐ Yes ☐ No
If YES, nature of work - please indicate ☐ Light ☐ Moderate ☐ Heavy

Part-time (15-30 hrs) ☐ Yes ☐ No
If YES, nature of work - please indicate ☐ Light ☐ Moderate ☐ Heavy

c) If the member 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.

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d) If return to **any** work is likely in the future, please state the:

nature of work

number of hours per week

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

When do you anticipate a graded return to work or increase in hours possible?

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

Investigation and/or referrals	Treatment	Prognosis

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Declaration

by medical practitioner completing this form

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

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 member 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

Address

Postcode

Telephone (W)

(H)

(Fax)

(M)

Registration and/or provider number

Qualifications

Specialty code

Signature Date / /