

PARLIAMENTARY
SUPERANNUATION
SCHEME PSS 3
CLAIM FOR
DISABLEMENT
ENTITLEMENTS
Form

Please complete all the details on this form in **BLOCK LETTERS** and return the signed original to Super SA.

1. PERSONAL DETAILS

Mr Ms Miss Mrs Dr Prof

Surname _____

Given name(s) _____

Residential address _____

Postcode _____

Postal address (if different from above) _____

Postcode _____

Date of birth / / _____

Super ID _____

Email _____

Telephone **WORK** _____

HOME _____

MOBILE _____

Please note that a claim cannot be paid until you:

- satisfy a judge that your ceasing to be a Member of the Parliament is due to ill health and that it prevents you from being able to carry out your duties of office to a reasonable degree. The Parliamentary Superannuation Board will seek a certificate on your behalf, and
- satisfy the Board that your incapacity for all kinds of work is 60% or more of total incapacity and is likely to be permanent.

CHECKLIST

- Complete and sign Part A: Member Statement (page 2).
- Provide Part B: Medical Report (page 3) to your medical practitioner to complete and sign.
- Return the signed original to Super SA.

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

Contact details

Telephone (08) 8226 9839

Website www.supersa.sa.gov.au/parliamentary_super

Mail GPO Box 48
Adelaide
SA 5001

Visit Ground Floor (enter from Pulteney Street)
151 Pirie Street
ADELAIDE SA 5000

Please complete all the details on this form and return the signed original to Super SA.

PART A: MEMBER STATEMENT

(to be completed by the member)

Did your condition(s) result from an accident?

Yes No

What is the exact nature of your medical condition(s)?

When did you first suffer from the above condition(s)?

What date did you last work?

Please give details of doctors, physiotherapists, chiropractors etc consulted in relation to the condition(s).

Condition(s)	Doctor's name	Doctor's address	Date of first consultation	Date of last consultation

What duties does your condition(s) prevent you from doing?

Please list any alternative duties that you think you may be able to do (if applicable)

Have you received, applied for, or are entitled to receive, any other entitlements?

Yes No

If YES, please give details

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 / /

Please complete all the details on this form and return the signed original to Super SA.

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

Investigation and/or referrals	Treatment	Prognosis

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

WORK

HOME

FAX

MOBILE

Registration and/or provider number

Qualifications

Specialty code

Signature

Date / /
