

# APPLY AND CHANGE SPOUSE DEATH INSURANCE



**SUPER SA**  
contributing to your future

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

## 1. 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, announcements, 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.

Additional units may be subject to limitations.

### Complete this form if you wish to:

- apply for Triple S Spouse Death Insurance
- apply for additional units of Standard or Fixed Benefit Insurance cover
- transfer to Standard or Fixed Benefit Insurance
- decrease your level of cover
- reduce your number of Fixed (closed) Insurance units.

### Please note:

- If you change your type of cover or purchase additional units of Standard or Fixed Benefit Insurance cover, new conditions may apply to these units of insurance.
- You cannot mix multiple types of cover at the same time.
- By choosing to transfer your insurance from Fixed (closed) Insurance you will be removing all your Fixed (closed) Insurance units and you will not be able to transfer back to Fixed (closed) Insurance.
- Spouse members are no longer able to apply for units of Fixed (closed) Insurance cover.

## 2. Level of insurance for Death Only

The maximum value of insurance you can have is \$1,500,000.

Please refer to the **Spouse Members and Spouse Accounts and Insurance** fact sheet when completing this form.

I require a **total number of Standard unit(s)** of cover:

- The value of a unit of Standard Insurance is based on your age.
- 1  2  3  4  5  6  7  8  
 9  10  11  Other (please state) \_\_\_\_\_

OR

I require a **total number of Fixed Benefit Insurance unit(s)** of cover:

Each Fixed Benefit Insurance unit has a value of \$10,000.

- 1  2  3  4  5  6  7  8  
 9  10  11  Other (please state) \_\_\_\_\_

OR

I wish to **reduce** my **Fixed (closed) Insurance<sup>1</sup>** cover and require the following number of **Fixed** units:

- 1  2  3  4  5  6  7  8  
 9  10  11  Other (please state) \_\_\_\_\_

I understand that by transferring Fixed (closed) Insurance<sup>1</sup> units, I am removing all my Fixed (closed) Insurance units and will not be able to transfer back to Fixed (closed) Insurance (closed to new applications since November 2014).

If you are requesting additional cover, please complete Sections 3, 4 and 5 over the page.



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## 3. Personal Statement

If you have elected to buy additional units of Standard or Fixed Benefit Insurance cover, you are required to complete this Personal Statement regarding your health.

If you need more space please attach additional pages.

1. **Height:** \_\_\_\_\_ cm **Weight:** \_\_\_\_\_ kg

2. Are you, or have you been, a smoker or used<sup>1</sup> any sort of tobacco product<sup>2</sup> in the last 5 years?

Yes  No

3. Do you have an illness/medical condition(s)<sup>3</sup> or disability?

Yes  No (If no, please proceed to question 7)

4. What is the exact nature of the illness/medical condition(s)<sup>3</sup> or disability?  
If more than one condition, please attach additional information.

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5. a) When did you first suffer from the above illness/medical condition(s)<sup>3</sup> or disability?

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b) Have you had any recurrence or symptoms arising from the illness/medical condition(s)<sup>3</sup> or disability?

Yes  No

c) Is/are the illness/medical condition(s)<sup>3</sup> or disability getting worse?

Yes  No

6. a) Are you still receiving treatment (including medication) for the illness/medical condition(s)<sup>3</sup> or disability?

Yes  No


If Yes, please give details:

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 Please ensure that **all the sections** of this form have been completed including:

- your height and weight and
- details of your doctor(s).

Incomplete sections will cause delays in processing.

<sup>1</sup> Use of tobacco includes smoking, chewing or sucking of a tobacco product or any other activity involving the consumption of a tobacco product.

<sup>2</sup> A tobacco product means a cigarette, cigar, cigarette or pipe tobacco, tobacco prepared for chewing or sucking, or snuff.

<sup>3</sup> A 'medical condition' is any disease, injury, disability, disorder, syndrome, infection, behaviour and atypical variations of structure and function that impact on or affect the physical and/or mental condition, and impairs normal function.

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b) What was the nature of any treatments?

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7. a) Have you ever consulted a doctor about some other illness/medical condition(s)<sup>3</sup> or disability which is not an existing medical condition?

Yes  No

If Yes, please give details:

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b) What was the exact nature of the illness/medical condition(s)<sup>3</sup> or disability?

If more than one condition, please attach additional information.

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c) When did you first suffer from the above illness/medical condition(s)<sup>3</sup> or disability?

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d) Have you had any recurrence or symptoms arising from the illness/medical condition(s)<sup>3</sup> or disability?

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e) What was the nature of the treatment?

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<sup>3</sup> A 'medical condition' is any disease, injury, disability, disorder, syndrome, infection, behaviour and atypical variations of structure and function that impact on or affect the physical and/or mental condition, and impairs normal function.

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8. Have you ever had any surgical procedures in relation to any illness/medical condition(s)<sup>3</sup> or disability?

Yes  No

If Yes, please give details:

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<sup>3</sup> A 'medical condition' is any disease, injury, disability, disorder, syndrome, infection, behaviour and atypical variations of structure and function that impact on or affect the physical and/or mental condition, and impairs normal function.

9. Do you intend to seek any medical advice or treatment in the next 6 months?

Yes  No

If Yes, please give details:

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## 4. Doctor's Details

Please provide the name(s) of doctor(s) for your most recent consultation.

**This section must be completed in all cases.**

**Doctor's name**

Doctor's address

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**Doctor's name**

Doctor's address

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**Doctor's name**

Doctor's address

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**Doctor's name**

Doctor's address

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# APPLY AND CHANGE SPOUSE DEATH INSURANCE



## 5. Spouse Member Declaration

- I understand that I am required to provide all information relating to medical advice, examination or treatment received by me and all information as to any illness/medical condition(s)<sup>3</sup> or disability suffered by me, or any symptoms suffered by me that may indicate an illness/medical condition(s)<sup>3</sup> or disability.
- I understand that an insurance entitlement may be reduced or not payable if the cause of my death is caused wholly or partly by a pre-existing illness/medical condition(s)<sup>3</sup> or disability, or an illness/medical condition(s)<sup>3</sup> arising out of a pre-existing illness/medical condition(s)<sup>3</sup> or disability, or a prescribed activity.
- I understand that non-disclosure will result in my insurance entitlement being withheld or reduced.
- 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/medical condition(s)<sup>4</sup> or disability, or injury, medical history, consultations, prescriptions or treatment. A photocopy 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 for insurance.
- I understand I will have to pay the cost of providing any medical evidence to support my application.
- I understand that the *Southern State Superannuation Regulations 2009* prescribe the Triple S Spouse member insurance arrangements.
- I acknowledge providing false or misleading information is an offence under the Triple S Act.

Signature: ✕

Date: / /

### Please ensure that all the sections of this form have been completed including:



- your height and weight and
- details of your doctor(s).

Incomplete sections will cause delays in processing. If you fail to disclose any relevant information, your insurance entitlement may be withheld or reduced.

### 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

<sup>3</sup> A 'medical condition' is any disease, injury, disability, disorder, syndrome, infection, behaviour and atypical variations of structure and function that impact on or affect the physical and/or mental condition, and impairs normal function.