SUPER SA SELECT

Government of South Australia

EARLY RELEASE DUE TO PERMANENT DISABLEMENT OR TERMINAL ILLNESS FORM

Please complete all the details on this form in BLOCK LETTERS using a BLACK PEN.
To commence the application process, please return the signed ORIGINAL to Super SA.

PERSONAL DETAILS

Account ID

☐ Mr ☐ Ms ☐ Miss ☐ Mrs ☐ Dr ☐ Prof

Surname

Given name(s)

Address

Postcode

Date of birth / /

Email*

Telephone* (M)

(W)

(H)

Agency/Division

Current Salary $

Status ☐ Full time ☐ Part time ☐ Casual

*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.

PART A: MEMBER STATEMENT

To be completed by the member:

Occupation (current/former)

Manager's name (current/former)

Title

Contact phone number

Type of entitlement being applied for

☐ Total and permanent disablement[1]

☐ Terminal illness[2]

[1] Please note that any claim for total and permanent disablement will, after approval by the Trustee, be subject to you terminating your employment. You should also note that it is necessary for Super SA to contact your employer in order to assess your claim.

[2] To be eligible for a terminal illness entitlement, two medical practitioners (one being a specialist in the relevant field) must certify that your illness or condition is likely to result in your death within the next 12 months.

Are you currently on paid leave? ☐ Yes ☐ No
(ie annual, long service, sick leave)

If yes, please give details

Have you terminated employment? ☐ Yes ☐ No

If yes, on what date did you terminate employment? / /

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? / /

Contact us

In person
Ground floor, 151 Pirie Street
Adelaide SA 5000

Postal
GPO Box 48, Adelaide, SA 5001

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

Website
www.supersa.sa.gov.au

Important

If you have insurance within your Triple S account you should also complete a Claim for Disablement Entitlements *form. This can be found in the* Making a TPD Claim – Triple S *kit on our website.*

Disclaimer

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

WFL0030

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

Other comments (which you believe may be relevant in the assessment of the claim)

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 report (if applicable). I also authorise Super SA to provide this information to any other medical practitioner for the purpose of assessing my claim. Super SA may provide a copy of this authority to the third party to obtain necessary information. 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.

Signature: **Date:** / /

! In order for your claim to be processed, you are required to have your Medical Practitioner and Specialist Medical Practitioner complete pages 3 and 5 of this form.

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PART B: MEDICAL PRACTITIONER'S STATEMENT

To be completed by the member's medical practitioner

I, _____

Full Name (Please use block letters)

being a legally qualified medical practitioner in Australia

certify that _____

Name of Patient (Please use block letters)

is suffering from _____

Illness/Condition(s)

I certify that the above named person is:

☐ Unlikely, because of ill-health (whether physical or mental), to engage in gainful employment for which he/she is reasonably qualified by education, training or experience.

or

☐ Suffering from a terminal medical condition which is likely to result in his/her death within twelve months.

Further medical evidence/information is attached ☐ Yes ☐ No

DECLARATION - BY MEDICAL PRACTITIONER COMPLETING THIS FORM

I hereby certify that I have personally attended the person 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 person 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 _____ Fax _____

Registration and/or provider number _____

Qualifications _____ Specialty Code _____

Signature: _____ **Date:** / /

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

PART C: SPECIALIST MEDICAL PRACTITIONER'S STATEMENT

To be completed by the member's specialist medical practitioner

I, _____

Full Name (Please use BLOCK LETTERS)

being a legally qualified medical practitioner in Australia

certify that _____

Name of Patient (Please use BLOCK LETTERS)

is suffering from _____

Illness/Condition(s)

I certify that the above named person is:

☐ Unlikely, because of ill-health (whether physical or mental), to engage in gainful employment for which he/she is reasonably qualified by education, training or experience.

or

☐ Suffering from a terminal medical condition which is likely to result in his/her death within twelve months.

Further medical evidence/information is attached ☐ Yes ☐ No

DECLARATION - BY MEDICAL PRACTITIONER COMPLETING THIS FORM

I hereby certify that I have personally attended the person 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 person 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 _____ Fax _____

Registration and/or provider number _____

Qualifications _____ Specialty Code _____

Signature: _____ **Date:** / /