CLAIM FOR RELEASE OF ENTITLEMENTS DUE TO PERMANENT DISABLEMENT

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

In person:
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

Website: supersa.sa.gov.au

Part A: Member Statement

1. Manager's name (current/former)
2. Manager's title
3. Manager's contact phone number
4. What date did you last work? / /
5. Have you terminated employment? ☐ Yes ☐ No
6. If yes, on what date did you terminate employment? / /
7. Have you received, applied for, or are you entitled to receive, weekly workers' compensation payments?

   ☐ Yes
   ☐ No

   If yes, please give details:

8. Injury Manager's name
9. Injury Manager's contact phone number
10. Have you received, or are you entitled to receive, a workers' compensation redemption ie under the *Return to Work Act*?

    ☐ Yes
    ☐ No

    If yes, please give details:

11. Have you received, applied for, or are you entitled to receive, any other entitlements (eg TVSP)?

    ☐ Yes
    ☐ No

    If yes, please give details :

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Part A: Member Statement

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12. Are you receiving a Disability Support Pension (DSP) or Veterans Affairs Pension (VAP)? ☐ Yes ☐ No

If yes, state type ☐ DSP or ☐ VAP

Pension no Date granted / /

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

14. If an injury, how did your injury occur?

15. Please provide the date of any surgery/procedures / /

16. Provide details of surgery/procedures

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

Important:

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Super SA, GPO Box 48, Adelaide, SA 5001

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16. Please give details of all doctors, specialists etc. consulted in relation to the condition(s)

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

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

17. Have you been able to perform any work (paid or unpaid) since you were disabled? ☐ Yes ☐ No

If yes, please provide details

18. Please list the work duties that you are not able to perform

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

20. Other comments/additional information (which you believe may be relevant in the assessment of this claim)

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21. To assist with the assessment of your claim, please provide copies of the following (if applicable)

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

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

Before posting in your form, please ensure the following sections have been completed and signed:

- All questions under Part A: Member Statement ☐
- Part B: Medical Report (to be completed by your medical practitioner) ☐
- Part C: Medical Specialist Report (to be completed by your medical specialist) ☐
- Copies of any supporting documentation is attached ☐

Please send all parts of this form together, to ensure we are able to process your claim.

Declaration

– I declare that all the information supplied by me is true and correct.

– I acknowledge 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 reports (if applicable).

– Super SA may provide a copy of this declaration to the third party to obtain necessary information.

– I authorise Super SA to provide 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 under the relevant Act and Regulations.

– I understand I will have to pay the cost of providing any medical evidence to support my application.

Signature: ✘ **Date:** / /

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CLAIM FOR RELEASE OF ENTITLEMENTS DUE TO PERMANENT DISABLEMENT

Part B: Medical Report (To be completed by the **claimant's 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 member treating doctor? / /
3. On what date did you first see the member in connection with his/her condition(s)? / /
4. Does the member have an appointment to see you again? ☐ Yes ☐ No If yes, please give date / /
5. Please complete the following in respect of the member'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
7. Any other comments which you believe may be relevant in the assessment of this claim

CLAIM FOR RELEASE OF ENTITLEMENTS DUE TO PERMANENT DISABLEMENT

Part B: Medical Report (To be completed by the **claimant's 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.

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 claimant 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

16. To assist with the assessment of this claim, 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 ☐

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

CLAIM FOR RELEASE OF ENTITLEMENTS DUE TO PERMANENT DISABLEMENT

Part B: Medical Report (To be completed by the **claimant's medical practitioner**)

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Declaration (By medical practitioner completing this form)

- I hereby certify that I have personally attended the claimant 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
- Super SA may provide copies of this report to the claimant or to any medical practitioner, 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 / /

Please Note

If all sections are not completed the processing of this claim will be delayed.

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CLAIM FOR RELEASE OF ENTITLEMENTS DUE TO PERMANENT DISABLEMENT

Part C: Medical Report (To be completed by a **medical specialist in the relevant field**)

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4. Does the member have an appointment to see you again? ☐ Yes ☐ No If yes, please give date / /
5. Please complete the following in respect of the member'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?	

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   If yes, is the condition likely to be terminal within: ☐ 12-24 months ☐ 2-5 years ☐ 5-10 years
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- Biopsy Reports ☐
- Orthopaedic Assessments ☐
- Hospital or Separation Reports ☐
- Return to Work Reports ☐

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

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Date / /

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