CLAIM FOR DISABLEMENT ENTITLEMENTS

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)

Employer

Your occupation

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.

If all sections are not completed and returned together as a complete package, processing of this claim will be delayed.

Part A: Member Statement

1. Type of entitlement being applied for:

☐ **Total & Permanent Disablement (TPD)**

- Please note that any claim for total and permanent disablement will, after approval by the Board, be subject to you terminating your employment on the grounds of invalidity.
- Preserved members, following approval from the Board, can receive their account balance.

☐ **Terminal Illness**

- 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 24 months.
- Lump Sum and Pension Scheme members are not eligible to claim a terminal illness benefit. These members can claim a TPD benefit and may be eligible for a terminal illness tax concession.

Please complete Personal Details, Part A, Part B & Part C.

☐ **Income Protection (temporary disability)**

Have you taken paid leave? ☐ Yes ☐ No

What date will approved paid leave cease? D D / M M / Y Y

Please complete Personal Details, Part A & Part B.

2. Scheme

☐ Pension ☐ Lump Sum
☐ Triple S ☐ Flexible Rollover Product

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

Email: supersa@sa.gov.au

Website: supersa.sa.gov.au

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CLAIM FOR DISABLEMENT ENTITLEMENTS

Part A: Member Statement

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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.

3. Manager's name (current/former)

4. Manager's title Manager's contact phone number

5. What date did you last work? / /

6. Have you terminated employment? ☐ Yes ☐ No

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

8. Have you received, applied for, or are you entitled to receive, weekly workers' compensation payments? ☐ Yes ☐ No

   If yes, please give details:

9. Injury Manager's name

10. Injury Manager's contact phone number

11. 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:

12. Have you received, applied for, or are you entitled to receive, any other entitlements (eg TVSP)? ☐ Yes ☐ No

    If you are claiming through your **Triple S account** and have terminated employment as a result of accepting a Targeted Voluntary Separation Package or Voluntary Separation Package (TVSP or VSP), you **are not** eligible to claim for TPD insurance, including Terminal Illness.

    If you are claiming through your **FRP account** and have terminated employment as a result of accepting a Targeted Voluntary Separation Package or Voluntary Separation Package (TVSP or VSP) and the incapacity was known to you at the time of accepting the TVSP or VSP, you **are not** eligible to claim for TPD Insurance, including Terminal Illness.

    If yes, please give details

13. 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 / /

Important information

Return to work entitlement: If you have received, or are entitled to receive, weekly workers' compensation payments, this may affect your entitlement.

Medical costs: You will have to pay the cost of providing any medical evidence to support your claim, such as obtaining the Medical Reports from your treating doctors and any supporting documentation. Where you attend an appointment with an independent medical examiner arranged by Super SA, the medical examiner's costs will be covered by Super SA. However, if an appointment is arranged and you do not attend the appointment, you will need to pay the cost of any non-attendance fee incurred.

Important:

– Please return the **original signed form and supporting information** to Super SA by post:

Super SA, GPO Box 48, Adelaide, SA 5001

CLAIM FOR DISABLEMENT ENTITLEMENTS

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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.

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

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

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

17. Provide details of surgery/procedures

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

19. 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.)

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

If yes, please provide details:

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

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

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

CLAIM FOR DISABLEMENT ENTITLEMENTS

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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.

24. 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 ☐

25. 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:** / /

Important:

- Please return the **original signed form and supporting information** to Super SA by post:

  Super SA, GPO Box 48, Adelaide, SA 5001

CLAIM FOR DISABLEMENT ENTITLEMENTS

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

SUPER SA
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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 claimant's treating doctor? / /
3. On what date did you first see the claimant in connection with his/her condition(s)? / /
4. Does the claimant have an appointment to see you again? ☐ Yes ☐ No If yes, please give date / /
5. Please complete the following in respect of the claimant'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 DISABLEMENT ENTITLEMENTS

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.

13. Please estimate the claimant's overall level of incapacity for all kinds of work.

☐ %

Note 100% incapacity means that the claimant is completely unable to perform any type of work.

CLAIM FOR DISABLEMENT ENTITLEMENTS

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.

14. To assist with the assessment of this 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	☐

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

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

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CLAIM FOR DISABLEMENT ENTITLEMENTS

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

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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 claimant's treating doctor? / /

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

4. Does the claimant have an appointment to see you again? ☐ Yes ☐ No If yes, please give date / /

5. Please complete the following in respect of the claimant'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 DISABLEMENT ENTITLEMENTS

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

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Based on your professional medical opinion:

8. Is the claimant fit for his/her **usual work**?

Full time (>30 hrs)	☐ Yes	☐ No		
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Nature of work – please indicate	☐ Light	☐ Moderate	☐ Heavy	☐ Other

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Test Results (eg blood tests) ☐	Biopsy Reports ☐	Return to Work Reports ☐

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

Declaration (By medical specialist 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 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

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  Adelaide, SA 5001