Personal health statement

Super SA

Government of South Australia

Please complete all the details on this form in **BLOCK LETTERS** using a **BLACK PEN** and return to Super SA via post or email.

You should complete this form if you have applied to change your cover using the "change my insurance" form and we asked you to attach this "personal health statement" to assess your application.

To find out more visit **supersa.sa.gov.au** or call **1300 369 315**

Client ID:

1. Personal details

Title

Date of birth D D / M M / Y Y Y Y

Given name(s)

Family name

2. Health information

1. Height (in cm) Weight (in kg)

2. Have you ever been approved a TPD/TI entitlement in any other SA government superannuation scheme? Yes No
If Yes, you may not be entitled to insurance.
(e.g. Triple S, Lump Sum, Pension Scheme, Super SA Flexible Rollover Product, Super SA Select, SA Ambulance Superannuation Scheme, SA Metropolitan Fire Service Super Scheme).

3. Are you, or have you been, a smoker or used[1] any sort of tobacco product[2] in the last 5 years? Yes No
If Yes

What type(s) of tobacco product[2]?

What brand(s) of tobacco product[2]?

How many times a day do you use a tobacco product? When did you first begin smoking? D D / M M / Y Y Y Y

If you have ceased smoking within the last five years, when did you cease? D D / M M / Y Y Y Y

4. Do you currently have an illness/medical condition(s)[3] or disability or symptoms that may indicate an illness? Yes No **If No, please proceed to question 8.**

Has this been diagnosed by a medical practitioner? Yes No **If Yes, when was the diagnosis?** D D / M M / Y Y Y Y

5. What is the exact nature of the illness/medical condition(s) or disability(s) or symptom(s) you are suffering that may indicate an illness/medical condition(s) or disability? *If more than one condition, please attach additional information.*

1 Use of tobacco includes smoking, chewing or sucking of a tobacco product or any other activity involving the consumption of a tobacco product.
2 A tobacco product means a cigarette, cigar, pipe tobacco, tobacco prepared for chewing or sucking, or snuff.
3 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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2. Health information (continued)

6. a) When did you first suffer from the above illness/medical condition(s) or disability(s) or symptoms you are suffering that may indicate an illness/medical condition(s) or disability? Please outline any recurrence of the illness/medical condition(s) or disability(s) or symptom(s).

b) Is/are the illness/medical condition(s) or symptom(s) or disability getting worse? Yes No

c) How many days have you been absent from your employment due to your illness/medical condition[3] in the last 12 months?

7. a) Are you receiving treatment (including medication) for the illness/medical condition(s) or disability? Yes No

If Yes, please give details:

b) What was the nature of any treatment?

8. a) Have you ever been diagnosed or consulted with, a medical practitioner in relation to a medical condition (including any symptoms that may have indicated a medical condition) or injury other than as listed above? Yes No

If Yes, you are required to provide the following details:

b) What is the exact nature of the illness/medical condition(s) or disability(s) or symptoms you are suffering that may indicate an illness/medical condition(s) or disability? Please outline any recurrence of the illness/medical condition(s) or disability(s) or symptom(s).

c) What was the nature of the treatment?

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2. Health information (continued)

9. Have you ever had any surgical procedures in relation to any illness/medical condition(s) or disability? Yes No

If Yes, please give details including dates:

10. Do you have any reason to believe that you will require medical advice or treatment in the next 6 months? Yes No

If Yes, please give details:

11. Are you taking any medications? Yes No

If Yes, please give details *(e.g. medication name, dosage, how long have you been taking it for)*:

12. Please provide the name(s) of doctor(s) or treating specialists for your most recent consultation due to all illnesses/medical condition(s) or disability being disclosed. *(If you need more space, please list and attach)*

Practitioner 1

Doctor's name

Phone number

Doctor's address

Suburb

State

Postcode

Practitioner 2

Doctor's name

Phone number

Doctor's address

Suburb

State

Postcode

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2. Health information (continued)

Practitioner 3

Doctor's name

Phone number

Doctor's address

Suburb

State

Postcode

3. 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)[3] or disability suffered by me, or any symptoms suffered by me that may indicate an illness/medical condition(s) or disability.

– I understand that I may have to provide additional medical evidence to support my application and I am responsible for any costs which may be incurred.

– I understand that in providing this information, I am required to disclose every matter that could reasonably be expected to be known by me, which may be relevant in Super SA's decision whether to accept the risk of insuring me.

– I understand that an insurance entitlement may be withheld (not payable) if the cause of my death or disability is caused wholly or partly by a preexisting illness/medical condition(s) or disability, or an illness/medical condition(s) or disability arising out of a pre-existing illness/medical condition(s) or disability, or a prescribed activity.

– I understand that non-disclosure may result in my insurance entitlement being deferred, reduced or declined.

– I understand that if I terminated public sector employment in connection with a voluntary separation package, I cannot claim a TPD insurance benefit.

– 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) or injury, medical history, consultations, prescriptions or treatment.

– I understand that Super SA and its medical adviser(s) will use this information for the purpose of considering my application for insurance. Super SA may approve, decline or accept an application subject to limitations.

- I have read and understood the relevant Product Disclosure Statement available on the Super SA website.

- I understand that the cost of the insurance cover will be deducted from my account.

- I acknowledge providing false or misleading information is an offence under the *Southern State Superannuation Act 2009*.

Signature ✘

Date D D / M M / Y Y Y Y

Contact us

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