Form > SA Ambulance Service Superannuation Scheme

APPLICATION FOR DISABLEMENT ENTITLEMENTS

SUPER SA
contributing to your future

Please complete all the details on this form and return the signed original to Super SA.

1. Personal Details

Super 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* (W)

(H)

(M)

Employee no

Current Salary

Status ☐ Full-time ☐ Part-time ☐ Casual

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 or 1300 369 315

Email
supersa@sa.gov.au

Website
www.supersa.sa.gov.au

*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 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)

Type of entitlement being applied for

- ☐ Release of preserved entitlement
- ☐ Income protection
- ☐ Serious ill health
- ☐ Permanent disablement

Occupation (current/former)

How long have you been in that occupation?

Please describe the nature of your duties

Manager's name (current/former)

Title Contact tel

Date of last day at work / /

What is your level of education (Primary, Secondary, Tertiary)?

What qualifications do you have?

Are you currently on paid leave (eg. annual, long service)?

☐ Yes ☐ No

If YES, please give details

Have you received, applied for, or are entitled to receive weekly workers' compensation payments?

☐ Yes ☐ No

If YES, please give details

Please note that any claim for total and permanent disablement or serious ill health will, after approval by the Board, be subject to you terminating your employment on the grounds of total and permanent disablement or serious ill health. you should also note that it is necessary for Super SA to contact your employer in order to assess your claim. **Disclaimer: If all sections are not completed the processing of your claim may be delayed.**

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Please complete all the details on this form and return the signed original to Super SA.

Did your condition(s) result from an accident? ☐ Yes ☐ No

What is the exact nature of your medical condition?

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

Please give details of doctors, physiotherapists, chiropractors, etc consulted in relation to the condition(s)

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

What duties does your condition(s) prevent you from doing?

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

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

Have you received, applied for, or are you entitled to receive, any other entitlements? (eg. sickness, unemployment benefits, other insurance income benefits) ☐ Yes ☐ No

If YES, please give details

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 / /

Member 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 Workcover reports (if applicable).
- I authorise Super SA to provide information to any other medical practitioner for the purpose of assessing my claim.
- A photocopy or facsimile 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.
- 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.

Signature: ✘ **Date:** / /

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Please complete all the details on this form and return the signed original to Super SA.

Part B: Medical Report

(to be completed by the member's medical practitioner)

From what date have you been the member's treating doctor? / /

On what date did you first see the member in connection with his/her condition? / /

Does the member have an appointment to see you again? ☐ Yes ☐ No

If YES, please give date / /

Please complete the following in respect of the member's medical condition(s):

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

Please estimate the member's overall level of capacity for work:

____% *Note that 100% capacity means that the member is completely fit for work*

Based on your professional medical opinion:

a) At the current time, is the member fit for his/her usual work?

Full-time (>30 hours) ☐ Yes ☐ No

If YES, please indicate the nature of work ☐ Light ☐ Moderate ☐ Heavy

Part-time (15-30 hours) ☐ Yes ☐ No

If YES, please indicate the nature of work ☐ Light ☐ Moderate ☐ Heavy

b) Is the member fit for any other alternative work?

Full-time (>30 hours) ☐ Yes ☐ No

If YES, please indicate the nature of work ☐ Light ☐ Moderate ☐ Heavy

Part-time (15-30 hours) ☐ Yes ☐ No

If YES, please indicate the nature of work ☐ Light ☐ Moderate ☐ Heavy

c) If the member is currently not fit for his/her usual work or alternative work, please estimate when, in your opinion, the member is likely to be able to return to **any** form of work.

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d) If return to any work is likely in the future, please state the:

nature of work

number of hours per week

e) If it is premature to express an opinion about when the member could return to work, please provide an estimate as to when an opinion could be expressed

Do you expect the member to ever return to his/her normal occupation? ☐ Yes ☐ No

If no, do you think the member is incapacitated to such an extent that he/she is unlikely ever to do a job for which he/she is reasonably suited by education, training or experience? ☐ Yes ☐ No

If no, please list examples of jobs, which in your opinion would be appropriate

Any other comments which you believe may be relevant in the assessment of the claim?

Investigation and/or referrals	Treatment	Prognosis

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Please complete all the details on this form and return the signed original to Super SA.

Declaration by medical practitioner completing this form

Is any further medical evidence/information attached ☐ Yes ☐ No

I hereby certify that I have personally attended the member 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 member 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

Suburb Postcode

Telephone (w) Fax

Registration and/or provider number

Qualifications

Specialty code

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

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Part C: Medical Report

(to be completed by a medical specialist in the relevant field)

From what date have you been the member's treating doctor? / /

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Does the member have an appointment to see you again? ☐ Yes ☐ No

If YES, please give date / /

Please complete the following in respect of the member's medical condition(s):

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Declaration by medical specialist completing this form

Is any further medical evidence/information attached ☐ Yes ☐ No

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