Form > SA Ambulance Service Superannuation Scheme

VOLUNTARY DEATH AND TOTAL AND PERMANENT DISABLEMENT INSURANCE

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

Email*

Telephone* (W)

(H)

(M)

Employee no

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 (for regional callers)

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.

If you wish to:

- purchase unit(s) of Voluntary Insurance or
- vary your number of Voluntary Insurance units

within the SA Ambulance Service Superannuation Scheme, you need to complete this form and return it to the address below.

If you are happy with the Death and TPD insurance cover you are provided with automatically in the scheme, you do not need to complete this form.

2. Level of Voluntary Cover

I wish to purchase

☐ 1 unit at a cost of $1.35 per week
☐ 2 units at a cost of $2.70 per week
☐ 3 units at a cost of $4.05 per week
☐ 4 units at a cost of $5.40 per week

3. Personal Statement

If you have elected to purchase units of Voluntary Insurance or purchase additional units, please complete this Personal Statement. If you need more space please attach additional pages.

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

2. Are you, or have you been, a smoker in the last five years? ☐ Yes ☐ No

3. Do you have or have you had any medical conditions(s)? ☐ Yes ☐ No

   If NO, please proceed to question 7.

4. What is the exact nature of any medical condition(s)?

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

   b) Have you had any recurrence or symptoms arising from the condition(s)? ☐ Yes ☐ No

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c) Is/are the condition(s) getting worse? ☐ Yes ☐ No

6. a) What was the nature of any treatment?

b) Are you still receiving treatment (including medication) for the condition(s)? ☐ Yes ☐ No

If YES, please give details:

7. Please provide the name(s) of doctor(s) for your most recent consultation due to the condition(s)

Doctor's name:	Doctor's name:
Doctor's address:	Doctor's address:
Postcode:	Postcode:
Date of last consultation:	Date of last consultation:

8. Have you ever had any operations or other procedures related to a medical condition? ☐ Yes ☐ No

If YES, please give details:

9. Are you aware of any circumstance(s) or prior medical condition(s) that might cause you to become disabled or have a shortened life span?

☐ Yes ☐ No

If YES, please give details:

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4. Declaration

- I understand that 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 reduced or withheld if the cause of my death or disability is due to any physical or mental disorder, symptom or condition that is caused by or arises from or is connected to any activity or medical condition(s) that exist at the time of this application.
- I understand that non-disclosure will result in my insurance entitlement being withheld or reduced.
- 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. A photocopy 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 for insurance.
- I understand that the cost of Voluntary cover will be deducted from my Award Account.

Signature ✘ ______________________ **Date** __________

Office use only:

New value of voluntary insurance $ ______________________

Previous No. of units: __________ Cost per week $ __________

Limitations: ☐ Y ☐ N

Date commenced: __________ Age: __________