

Please complete all the details on this form in **BLOCK LETTERS** using a **BLACK PEN** and return the signed original to Super SA.

1. PERSONAL DETAILS

Account ID

Mr Ms Miss Mrs Dr Prof

Surname

Given name(s)

Address

Postcode

Postal address (if different from above)

Postcode

Date of birth / /

Email*

Telephone* (M)

(W)

(H)

Name of employer

Employee number

*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 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

Postal

GPO Box 48, Adelaide, SA 5001

Call

(08) 8207 2094 or 1300 369 315 (for regional callers)

Website

www.supersa.sa.gov.au

IMPORTANT

Complete the Triple S *Leave Without Pay* form if you **do not** wish to maintain your Death and Total and Permanent Disablement (TPD) Insurance cover through the Triple S Scheme.

2. NOTIFICATION OF LEAVE WITHOUT PAY

a) Period of leave without pay

/ / to / /

b) Period of any leave (eg long service leave or annual leave) taken with leave without pay
(leave blank if not applicable)

/ / to / /

c) Is this leave an extension of previous approved leave without pay?

Yes No

If yes, please provide the date of previous leave without pay

/ / to / /

d) Reason or purpose for leave without pay

3. MEMBER DECLARATION

I certify that the dates provided above are true and correct.

I understand that:

- I am not entitled to any super contributions from my employer while on Leave Without Pay.
- to amend any insurance I have in the Triple S Scheme I must complete the Triple S *Leave Without Pay* form.

Signature: 

Date: / /

Members

Please forward the completed form to your pay office for completion of section 4 over the page.



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4. AGENCY AUTHORISATION - BY THE AUTHORISED OFFICER

Authorised Officers

Please forward completed form to Super SA.



I certify that the information in Section 2 of this form is correct.

Member's salary prior to leave without pay:

Full-time \$

Part-time \$

Agency name

Agency location

Signature of Authorised Officer ✕

Name of Authorised Officer (please print)

Telephone

Date

/ /