CHANGE DEATH AND TPD INSURANCE

SUPER SA
contributing to your future

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)

Residential address

Postcode

Postal address (if different from above)

Postcode

Date of birth / /

Email*

Telephone*(M)

(W)

(H)

* 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.

Only complete this form if you wish to:

- apply for additional units of Standard or Fixed Benefit Insurance cover
- transfer to Standard or Fixed Benefit Insurance
- decrease your level of cover
- reduce your number of Fixed (closed) Insurance units.

If you are happy with your current Death and Total & Permanent Disablement (TPD) Insurance you do not need to complete this form.

Please note:

- If you change your type of cover or purchase additional units of Standard or Fixed Benefit Insurance cover, new conditions may apply to these units of insurance.
- You cannot mix multiple types of cover at the same time.
- By choosing to transfer your insurance from Fixed (closed) Insurance you will be removing all your Fixed Insurance units and you will not be able to transfer back to Fixed Insurance.
- Members are no longer able to apply for units of Fixed (closed) Insurance cover.

2. Employment Details

Occupation

Are you employed as an operational Ambulance employee?

☐ Yes ☐ No

Are you employed as a Police Officer?

☐ Yes ☐ No

If you are employed as a Police Officer or operational Ambulance employee, you must maintain an equivalent minimum of six (6) Standard Insurance units to age 65.

Employment status

☐ Full-time ☐ Part-time ☐ Casual

Note: If you are a casual employee you need to work at least nine hours per week, or for periods that average nine hours or more per week over a three-month period, to be eligible to buy additional units. You are not required to have insurance and can cancel it by completing and returning a *Cancel Death and TPD Insurance* form

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3. Level of insurance for Death and TPD

The maximum value of insurance you can have is:

- $1,500,000 if you are a full or part-time employee
- $750,000 if you are a casual employee.

Please refer to the Triple S Death and TPD Insurance fact sheet for further information on levels of cover per unit.

☐ I require a **total number of Standard Insurance unit(s)** of cover:
The value of a unit of Standard Insurance is based on your age.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8
☐ 9 ☐ 10 ☐ 11 ☐ Other (please state) _____

Additional units may be subject to limitations.

OR

☐ I require a **total number of Fixed Benefit Insurance unit(s)** of cover:
Each Fixed Benefit Insurance unit has a value of $10,000.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8
☐ 9 ☐ 10 ☐ 11 ☐ Other (please state) _____

OR

☐ I wish to **reduce** my **Fixed Insurance**[1] cover and require the following number of **Fixed Insurance** units:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8
☐ 9 ☐ 10 ☐ 11 ☐ Other (please state) _____

I understand that by transferring Fixed Insurance[1] units, I am removing all my Fixed Insurance units and will not be able to transfer back to Fixed Insurance[1].

[1] Closed to new applications since November 2014.

If you are requesting additional cover, please complete Sections 4, 5 and 6 over the page.

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4. Personal Statement

If you are applying for additional units of Standard or Fixed Benefit Insurance cover, you are required to complete this Personal Statement regarding your health.

If you need more space please attach additional pages.

1. **Height**: cm **Weight**: kg

2. Are you, or have you been, a smoker or used[2] any sort of tobacco product[3] in the last 5 years?

☐ Yes ☐ No

3. Do you have an illness/medical condition(s)[4] or disability?

☐ Yes ☐ No (If no, please proceed to question 7)

4. What is the exact nature of the illness/medical condition(s)[4] or disability?

If more than one condition, please attach additional information.

Please ensure that **all the sections** of this form have been completed including:

- your height and weight and
- details of your doctor(s).

Incomplete sections will cause delays in processing.

5. a) When did you first suffer from the above illness/medical condition(s)[4] or disability?

b) Have you had any recurrence or symptoms arising from the illness/medical condition(s)[4] or disability?

☐ Yes ☐ No

c) Is/are the illness/medical condition(s)[4] or disability getting worse?

☐ Yes ☐ No

6. a) Are you still receiving treatment (including medication) for the illness/medical condition(s)[4] or disability?

☐ Yes ☐ No

If Yes, please give details:

[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, cigarette or 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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b) What was the nature of any treatment?

7. a) Have you ever consulted a doctor about some other illness/medical condition(s)[4] or disability which is not an existing medical condition?

☐ Yes ☐ No

If Yes, please give details:

b) What was the exact nature of the illness/medical condition(s)[4] or disability?

If more than one condition, please attach additional information.

c) When did you first suffer from the above illness/medical condition(s)[4] or disability?

d) Have you had any recurrence or symptoms arising from the illness/medical condition(s)[4] or disability?

e) What was the nature of the treatment?

[4] 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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8. Have you ever had any surgical procedures in relation to any illness/medical condition(s)[4] or disability?

☐ Yes ☐ No

If Yes, please give details:

[4] 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.

9. Do you intend to seek any medical advice or treatment in the next 6 months?

☐ Yes ☐ No

If Yes, please give details:

5. Doctor's Details

Please provide the name(s) of doctor(s) for your most recent consultation.
This section must be completed in all cases.

Doctor's name

Doctor's address

Doctor's name

Doctor's address

Doctor's name

Doctor's address

Doctor's name

Doctor's address

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6. 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)[4] or disability suffered by me, or any symptoms suffered by me that may indicate an illness/medical condition(s)[4] or disability.
- I understand that an insurance entitlement may be reduced or not payable if the cause of my death or disability is caused wholly or partly by a pre-existing illness/medical condition(s)[4] or disability, or an illness/medical condition(s)[4] or disability arising out of a pre-existing illness/medical condition(s)[4] or disability, or a prescribed activity.
- I understand that non-disclosure will result in my insurance entitlement being withheld, reduced or declined.
- 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)[4] or disability, 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 I will have to pay the cost of providing any medical evidence to support my application.
- I understand that the *Southern State Superannuation Regulations 2009* prescribe the Triple S insurance arrangements.
- I acknowledge providing false or misleading information is an offence under the *Southern State Superannuation Act 2009*.

Casual Employee Declaration

- If I am a casual employee I declare that I work at least nine hours per week or for periods that average nine hours or more per week over a three-month period.

Signature: ✘ **Date:** / /

Please ensure that all the sections of this form have been completed including:

- your height and weight and
- details of your medical practitioner(s).

Incomplete sections will cause delays in processing. If you fail to disclose any relevant information, your insurance entitlement may be withheld, reduced or declined.

Contact us

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Call
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1300 369 315 (for regional callers)

Email
supersa@sa.gov.au

Website
supersa.sa.gov.au

[4] 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.