Form > Super SA

INCOME PROTECTION REVIEW FORM

SUPER SA
contributing to your future

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

1. Personal Details

☐ Mr ☐ Ms ☐ Miss ☐ Mrs ☐ Dr ☐ Prof

Surname

Given name(s)

Residential address

Postcode

Postal address (if different from above)

Postcode

Date of birth / /

Super ID

Email*

Telephone* (M)

(W)

(H)

* If you provide your email address and/or mobile number, then Super SA will be able to contact you in a timely manner about your super. You can also stay informed with e-newsletters and Super SA may from time to time also send additional communications by electronic means, including Super SA announcements, invitations and surveys.You may opt out of the email and/or mobile phone service at any time.

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
1300 369 315 (for regional callers)

Email
supersa@sa.gov.au

Website
www.supersa.sa.gov.au

Part A: Member Statement

To be completed by the member

Have you received any pay for work performed or received paid leave in the last three months?

☐ 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

Have you received, applied for, or are entitled to receive, any other entitlements (eg TVSP)?

☐ Yes ☐ No

If yes, please give details

Declaration

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

- I declare that all the information supplied by me is true and correct.
- 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 medical report (if applicable).
- I also authorise Super SA to provide this 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 so for the purpose of assessing my claim under the relevant Act and Regulations.
- I understand I will have to pay the cost of providing any medical evidence to support my review.

Signature: ✘ **Date:** / /

Part B: Medical Report is on pages 2 and 3.

This section is to be completed by your medical practitioner.

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Part B: Medical Report

To be completed by your 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(s)? / /

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):

Diagnosis	Functional consequences

Please estimate the member's overall level of incapacity for all kinds of work _____ %.

Level of incapacity must be completed.

(Note: 100% incapacity means the member is completely unable to work)

Based on your professional medical opinion:

b) Is the member fit for his/her usual work?

> Full-time (>30 hrs) ☐ Yes ☐ No

If yes, nature of work – please indicate ☐ Light ☐ Moderate ☐ Heavy

> Part-time (15-30 hrs) ☐ Yes ☐ No

If yes, nature of work – please indicate ☐ Light ☐ Moderate ☐ Heavy

c) Is the member fit for **any** other alternative work?

> Full-time (>30 hrs) ☐ Yes ☐ No

If yes, nature of work – please indicate ☐ Light ☐ Moderate ☐ Heavy

> Part-time (15-30 hrs) ☐ Yes ☐ No

If yes, nature of work – please indicate ☐ Light ☐ Moderate ☐ Heavy

d) 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.

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

nature of work number of hours per week

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f) When do you anticipate a graded return to work or increase in hours possible?

g) 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.

h) Is the member's condition terminal? ☐ Yes ☐ No

If yes, what is the member's life expectancy? ☐ < 12 months ☐ 12 – 24 months ☐ 2 – 5 years ☐ 5 – 10 years

i) Any other comments which you believe may be relevant in the assessment of this claim:

Investigation and/or referrals	Treatment	Prognosis

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 Postcode

Telephone (Work) (Home)

(Fax) (Mobile)

Registration and/or provider number

Qualifications

Specialty code

Signature: ✘ **Date:** / /