# Permanent incapacity claim

**Member statement**

## About this form

You can use this form to apply for early release of your superannuation account balance if you are injured or ill and as a result are permanently unable to work. A permanent incapacity benefit is a payment made only from your super account balance and there is no insurance cover attached to the account.

### 1 – Your personal details

Title
Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐☐☐

Sex
Male ☐ Female ☐

Date of birth (ddmmyyyy)

Member number

First name

Last name

Business hours phone

After hours phone

Mobile

Email

### 2 – Claim details

**(a)** Is the claim based on:

☐ Injury - date of injury (ddmmyyyy)

☐ Illness - date of onset of illness (ddmmyyyy)

Nature of injury or illness

**(b)** Did you stop working solely due to injury or illness (as stated above)?

☐ No ☐ Yes, on what date (ddmmyyyy)

**(c)** Have you been advised by a doctor that you will never be able to work again as a result of your illness or injury?

☐ No - *you are not eligible to claim a PI benefit* ☐ Yes, on what date (ddmmyyyy)

**(d)** Has you employment been formally terminated?

☐ No - *you are not eligible to claim a PI benefit* ☐ Yes, on what date (ddmmyyyy)

### 3 – Employment details of your last employer

Name of business

Address

Suburb

State

Postcode

## Need help?

Call us on 1800 682 626 or www.equipsuper.com.au Equip, GPO Box 4303, Melbourne VIC 3001

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HR representative

First name

Last name

Business hours phone

Email

## 4 – Qualifications, education, training & experience

**(a)** What level of education do you have? e.g. Primary, Secondary, Tertiary, Trade/TAFE

**(b)** What formal qualifications, industry qualifications or certificates do you have?

**(c)** How well do you:

| | | | |
|---|---|---|---|
| Speak English | ☐ Good | ☐ Average | ☐ Poor |
| Read English | ☐ Good | ☐ Average | ☐ Poor |
| Write English | ☐ Good | ☐ Average | ☐ Poor |

**(d)** Please list all previous jobs you have held (attach a separate page if space is insufficient):

| **Job title** | **Description of duties** | **From** (ddmmyyyy) | **To** (ddmmyyyy) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## 5 – Sign the form

**By signing this form I:**

- confirm that the information I have provided is true and correct
- understand there may be a delay in assessing my eligibility for a permanent incapacity benefit if I do not provide the required documents.

Signature

Date (ddmmyyyy)

☐ If you wish to provide payment instructions with this application, you will need to complete and attach a **Benefit payment application** form along with the required proof of identity or any other document as outlined on that form.

**Your general practitioner and specialist must refer to this form to complete their medical reports. Please return this completed form and all the relevant documents to: Equip, GPO Box 4303, Melbourne VIC 3001**

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# General practitioner medical report

## Permanent incapacity

## About this form

Your patient has lodged a permanent incapacity claim with Equip. Please complete this form as the patient's medical practitioner with the view to providing as much information as possible to assist in the assessment of their claim. Should the form contain insufficient space to provide all information, please attach additional pages that are clearly marked with the question number reference and ensure you sign and date each page. The fee charged for completion of this report is the responsibility of the patient.

## 1 – Patient personal details

Title
Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐☐☐

Sex
Male ☐ Female ☐

Date of birth (ddmmyyyy)

Member number

First name

Last name

Business hours phone

After hours phone

Mobile

Email

## 2 – General practitioner details

Doctor's name

Qualification

Address

Suburb

State

Postcode

Country (if not Australia)

Business hours phone

**(a)** Are you the patient's usual treating medical practitioner? ☐ Yes ☐ No

**(b)** Are you currently treating the patient? ☐ Yes ☐ No

**(c)** How long have you known the patient? Years / Months

**(d)** Date of first consultation (ddmmyyyy) **AND** Date of last consultation (ddmmyyyy)

**(e)** Please provide details of any other doctor you referred the patient to for opinion, investigation or treatment.

| **Referred to** | **Reason for referral** | **Date referred** (ddmmyyyy) |
|---|---|---|
| Doctor's name: | | |
| Doctor's name: | | |
| Doctor's name: | | |

## 3 – Medical condition details

**(a)** What is the medical diagnosis?

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**(b)** Date of diagnosis. (ddmmyyyy)

**(c)** Is the condition terminal?

☐ No ☐ Yes, date became terminal and patient's estimated life expectancy Years or Months

**(d)** What are the current reported symptoms?

**(e)** What treatment has been undertaken?

**(f)** If tests have been performed, please attach a copy of the results/report. ☐ Attached ☐ NA

**(g)** Please provide details of any future treatment planned or necessary.

**(h)** Has hospital admission been necessary for this condition? ☐ No ☐ Yes – complete the table below

| Hospital | Reason for admission | Admission / discharge |
|---|---|---|
| Name: | | Admission (ddmmyyyy) |
| Address: | | |
| | | Discharge (ddmmyyyy) |
| Phone: | | |

**(i)** Do you consider the condition to be connected in any way with a previous illness or injury or unfavorable features of the patient's history?

☐ No ☐ Yes – please provide details below

**(j)** **Please refer to the Permanent incapacity member statement together with the answers you have provided within this form. In your opinion, considering their ill-health, is the patient ever likely to engage in gainful employment for which they are reasonably qualified by their education, training or experience?**

☐ No ☐ Yes

## 4 – General practitioner declaration

I certify that I have personally attended the above named patient and that all information provided by me on this form is true, correct and complete. I agree that Togethr Trustees Pty Ltd may provide copies of this statement to any medical specialist, or independent specialists or any other person or organisation deemed necessary to assist in the assessment of this claim. I acknowledge my patient's authorisation for me to provide Togethr Trustees Pty Ltd with the enclosed information.

First name

Last name

Signature

✗

Date (ddmmyyyy)

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# Specialist medical report

## Permanent incapacity

## About this form

Your patient has lodged a permanent incapacity claim with Equip. Please complete this form as the patient's medical practitioner with the view to providing as much information as possible to assist in the assessment of their claim. Should the form contain insufficient space to provide all information, please attach additional pages that are clearly marked with the question number reference and ensure you sign and date each page. The fee charged for completion of this report is the responsibility of the patient.

## 1 – Patient details

Title
Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐☐☐

Sex
Male ☐ Female ☐

Date of birth (ddmmyyyy)

Member number

First name

Last name

Business hours phone

After hours phone

Mobile

Email

## 2 – Specialist details

Doctor's name

Qualification

Address

Suburb

State

Postcode

Country (if not Australia)

Business hours phone

**(a)** Are you the patient's usual **treating specialist practitioner?** ☐ Yes ☐ No

**(b)** Are you currently treating the patient? ☐ Yes ☐ No

**(c)** How long have you known the patient? Years / Months

**(d)** Date of first consultation (ddmmyyyy) **AND** Date of last consultation (ddmmyyyy)

## 3 – Medical condition details

**(a)** What is the medical diagnosis and its probable cause?

**(b)** Date of diagnosis. (ddmmyyyy)

**(c)** Is the condition terminal?

☐ No ☐ Yes, date became terminal and patient's estimated life expectancy Years or Months

## Need help?

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**(d)** What are the current reported symptoms?

**(e)** What treatment has been undertaken?

**(f)** If tests have been performed, please attach a copy of the results/report. ☐ Attached ☐ N/A

**(g)** Please provide details of any future treatment planned or necessary.

**(h)** Has hospital admission been necessary for this condition? ☐ No ☐ Yes – complete the table below

| Hospital | Reason for admission | Admission / discharge |
|---|---|---|
| Name: | | Admission (ddmmyyyy) |
| Address: | | |
| | | Discharge (ddmmyyyy) |
| Phone: | | |

**(i)** Do you consider the condition to be connected in any way with a previous illness or injury or unfavorable features of the patient's history?

☐ No ☐ Yes – please provide details below

**(j) Please refer to the Permanent incapacity member statement together with the answers you have provided within this form. In your opinion, considering their ill-health, is the patient ever likely to engage in gainful employment for which they are reasonably qualified by their education, training or experience?**

☐ No ☐ Yes

## 4 – Specialist declaration

I certify that I have personally attended the above named patient and that all information provided by me on this form is true, correct and complete. I agree that Togethr Trustees Pty Ltd may provide copies of this statement to any medical specialist, or independent specialists or any other person or organisation deemed necessary to assist in the assessment of this claim. I acknowledge my patient's authorisation for me to provide Togethr Trustees Pty Ltd with the enclosed information.

First name

Last name

Signature

X

Date (ddmmyyyy)

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