Terminal Illness
Member Statement

About this form

You can use this form to apply for the early release of your account balance and any related insured benefit due to a Terminal Medical Condition.

The attached General practitioner medical report and Specialist medical report must also be completed by your doctors and returned as part of your terminal illness claim. Both practitioners must certify that your illness is likely to result in your death within 24 months from the date of their certification. This period must not have ended and at least one of the medical practitioners must be a specialist **practicing in the area** related to your illness.

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 – Medical condition details

(a) Nature of the medical condition for which you are claiming?

(b) Date of illness onset

(c) Date of diagnosis

(d) Have you ever experienced similar symptoms at any time in the past?

☐ No

☐ Yes – Please provide details in (e) below

(e) Please provide details of the nature of your symptoms and your treatment.

Date symptoms first noticed (ddmmyyyy)	**Nature of symptoms**	**Treatment**

Need help?

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

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(f) Name and address of all doctors consulted for your condition, including dates of first and last consultation(s).
Please provide the same information in a separate sheet if you consulted more than two doctors in relation to your condition.

Doctor's name (1)

Speciality

Address

Suburb

State | Postcode | Country (if not Australia) | Business hours phone

Reason for seeing the doctor.

Date of first consultation (ddmmyyyy) | Date of last consultation (ddmmyyyy)

Are you receiving ongoing treatment from this doctor? ☐ Yes ☐ No

Doctor's name (2)

Speciality

Address

Suburb

State | Postcode | Country (if not Australia) | Business hours phone

Reason for seeing the doctor.

Date of first consultation (ddmmyyyy) | Date of last consultation (ddmmyyyy)

Are you receiving ongoing treatment from this doctor? ☐ Yes ☐ No

(g) Have you **ever** been paid, or were entitled to be paid, a TPD or Terminal Illness benefit from **any** insurer or superannuation fund?

☐ No

☐ Yes - What type of benefit was paid:

- Date you were entitled to be paid :
- On what date was the benefit paid:

(h) Have you ceased work?

☐ No

☐ Yes - On what date:

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3 – Your authority to release information to a third party

To assist with the claims process you may want a family member, friend or other party to be able to make *enquiries* about your claim. You should ensure you have their consent for their personal details below to be given to Equip and/or its insurer.

First name

Last name

Relationship to me

Date of birth (ddmmyyyy)

First name

Last name

Relationship to me

Date of birth (ddmmyyyy)

Privacy

The personal information you provide on this form will be used in accordance with Equip's Privacy Statement, which you can view online at **www.equipsuper.com.au/privacy** or you can obtain a copy by contacting us on 1800 682 626.

We collect, use and disclose personal information about you in order to manage your superannuation benefits and give you information about your super. We may also use it to supply you with information about the other products and services offered by us and our related companies. If you do not wish to receive marketing material, please contact us on 1800 682 626. You can also manage your communication preferences via Equip's secure website or by following any instructions in the emails we may send you.

Equip's Privacy Statement details how we deal with your personal information and who you can talk to if you wish to access and seek correction of the information we hold about you. It includes details on how we collect, disclose and manage your personal information, including other entities and offshore locations that may receive or provide your information. Our administrator, Mercer Outsourcing (Australia) Pty Ltd, will also handle your personal information. You can view Mercer's Privacy Policy online at **www.mercer.com.au/privacy.html**.

If you have any other queries in relation to privacy issues, you can contact us or write to our Privacy Officer, GPO Box 4303, Melbourne VIC 3001.

4 – Declaration and authority

By signing this form I:

(a) declare that I have reviewed the answers in this form and they are true and complete (including any responses not in my handwriting). I have not made any false or misleading statement and I have included all information relevant to the assessment of my claim.

(b) understand that if I do not give the information requested by Togethr Trustees Pty Ltd or its representative that they may not be able to assess, investigate or pay my claim.

(c) understand that Togethr Trustees Pty Ltd will disclose, collect and use the information covered by this declaration and authority solely for the purpose of its administration of this claim, and not for any other purpose.

(d) hereby authorise Togethr Trustees Pty Ltd to disclose my personal information (which may include sensitive or health information) to the following parties. I further consent to these parties collecting information about me and releasing to Togethr Trustees Pty Ltd their report, including any information they may hold about me as relates to the administration of my benefit and any insurance policy, including this claim.

- Any physician, hospital or any other healthcare provider who has attended or examined me in order for them to supply Togethr Trustees Pty Ltd with full particulars of my medical history including copies of all hospital or medical records, referral letters, reports and details of any clinical notes that have been made.
- Any claims assessor, investigator, medical professional, healthcare provider, insurance reference service, credit reference service, legal or accounting firm, auditor, employer, consultant or reinsurer for the purpose of producing a report concerning my claim.
- Any benefit provider such as other insurers or government departments (including workers' compensation insurers, Centrelink or similar benefit providers) that provides benefits in the event of my sickness and/or injury.

(e) authorise Togethr Trustees Pty Ltd and/or its insurer to respond to enquiries from nominated persons I have recorded in section 3 about my claim and I understand that such information may include my health, lifestyle, employment, financial, and insurance information.

First name

Last name

Signature

X

Date (ddmmyyyy)

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General practitioner medical report

Terminal Illness

About this form

Your patient has lodged a Terminal Illness 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 and its probable cause?

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(b) Date of diagnosis. (ddmmyyyy)

Date condition became terminal. (ddmmyyyy)

What is the patient's life expectancy?

Months

(c) What are the current reported symptoms?

(d) What treatment has been undertaken?

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

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

(g) 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:		

(h) 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

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)

Please return this form and any attachments to Equip, GPO Box 4303, Melbourne Vic 3001.

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Specialist medical report

Terminal illness

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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 it's probable cause?

(b) Date of diagnosis. (ddmmyyyy)

Date condition became terminal. (ddmmyyyy)

What is the patient's life expectancy? Months

(c) What are the current reported symptoms?

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(d) What treatment has been undertaken?

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

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

(g) 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:		

(j) 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

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)

Please return this form and any attachments to Equip, GPO Box 4303, Melbourne Vic 3001.

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