Permanent Incapacity Claim – Certificate of Specialist Medical Attendant

Please ensure that every question is answered. Incomplete forms will be returned.

Note: ANY CHARGE FOR THE COMPLETION OF THIS FORM MUST BE PAID BY THE PATIENT.

If you need help

For assistance call our **Helpline** on **1800 682 626**.

Step 1 – Complete patient's details

Please print in black or blue pen, in uppercase, one character per box. A ✓

Title Mr ○ Mrs ○ Ms ○ Miss ○ Other ☐☐☐ Date of birth ☐☐ / ☐☐ / ☐☐☐☐

Given names

Surname

Residential address **(must be advised)**

Suburb State Postcode

Postal address (if different to above)

Suburb State Postcode

Daytime Telephone ☐☐ - ☐☐☐☐☐☐☐☐ Mobile ☐☐☐☐ - ☐☐☐☐☐☐

E-mail

Membership number

Employer/Plan Number

Name of your employer

Issued by Equipsuper Pty Ltd ABN 64 006 964 049 AFSL 246383 as Trustee for Equipsuper Superannuation Fund ABN 33 813 823 017 SPIN EPL0100AU.

Step 2 – Provide details of member's condition

1. Please state the diagnosis. If applicable indicate the severity of the condition.

2. Please list the member's most recent occupation.

3. Please list member's past occupations.

4. Please list the member's training, education and experience.

5. Please refer to sections 2, 3 and 4 on this form. In your opinion, is the patient ever likely to resume duties in any occupation for which they are reasonably qualified by their past education, training or experience?

☐ Yes ☐ No

Step 3 – Sign the form

I acknowledge my patient's authorisation for me to provide the Trustee with any information that may be required in the consideration of this patient's application for early release of preserved benefits.

Doctor's Full Name

Address

Suburb State Postcode

Daytime Telephone Mobile

Medical Qualifications

Signature

✗

Date

/ /

Please return your completed form to Equipsuper, GPO Box 4303, Melbourne VIC 3001.