CareSuper

Terminal illness claim form

INSTRUCTIONS

Use this form to apply for the early release of your benefit on the grounds of terminal illness.

- You will need to ask two different registered medical practitioners to complete the **Terminal illness certificates** enclosed with this form.
- At least one of the registered medical practitioners must be a specialist practising in a field related to the illness or injury suffered.
- Each registered medical practitioner must certify the statement they provide (either in this form, or on their letterhead).

You'll be responsible for paying any costs associated with the completion of these forms.

Payment of your entitlement is subject to Trustee approval.

Please complete all sections of this form as applicable, sign at Section 4, and return the completed form to CareSuper. If you are unable to sign due to incapacitation, please call us on **1300 090 925** to make alternative arrangements.

Complete this form in blue or black pen using BLOCK LETTERS and tick ✓ where applicable.

If you have insurance cover or need help completing this form, call us on **1300 090 925** to check if you need to complete any additional forms.

You can also check your insurance by logging in to your account at **caresuper.com.au/login**.

CHECK YOU'RE ELIGIBLE TO CLAIM

You may be eligible to claim your account balance on the grounds of terminal illness if you meet the following conditions:

- Two registered medical practitioners have certified you suffer from an illness or an injury, that is likely to result in your passing within 24 months after the date of certification;
- At least one of the registered medical practitioners is a specialist practising in a field related to your illness or injury.

IDENTIFICATION REQUIRED FOR ALL CLAIMS

For security reasons, you must provide certified copies of identification documents. I have included with my claim a certified copy of:

One primary photographic identification document

- ☐ Driver licence
- ☐ Passport

OR

A primary non-photographic identification document

- ☐ Birth certificate
- ☐ Citizenship certificate
- ☐ Centrelink pension card

AND

A secondary identification document

- ☐ Centrelink payment letter
- ☐ Government or local council payment notice (less than one year old) clearly showing your name and residential address

SAMPLE CERTIFICATION

I certify this is a true copy of an original document.

Name: Adam B. Sample

Signature: A Sample

Qualification: Police officer, Victoria Police

Dated: 30/03/2019

Contact no: 0123 456 789

For other acceptable forms of identification and a full list of people able to certify your ID, visit **caresuper.com.au/certifyingid** or call **1300 090 925**.

PROVIDING IDENTIFICATION

You must provide certified copies of identification documents. Your name must be the same as shown on your proof of identity. If you've changed your name, you'll also need to provide a certified copy of your change of name document — for example, your marriage certificate or change of name documentation.

The identification must be current and the copy must have been certified within six months of being received by CareSuper.

CR/INS/TI/CLAIM 1462.8 05/23 ISS2

SECTION 1. YOUR PERSONAL DETAILS

Member account number

Date of birth (DD/MM/YYYY)

Title

Surname

Given names

Residential address (required)

Suburb

State/territory

Postcode

Postal address (if different from above)

Suburb

State/territory

Postcode

Mobile

Daytime telephone

Email

Your name must be the same as shown on your proof of identity, or additional change of name documentation must also be provided.

SECTION 2. YOUR TAX FILE NUMBER (TFN)

You are not obliged to provide your TFN to Caresuper. However, if you do not provide it:

- You might pay more tax on your super payout. Sometimes you may be able to claim this tax back, however time limits and other rules may apply
- We may not be able to accept contributions for you
- It may be more difficult for you to monitor your account or to locate it if you lose track of it.

CareSuper is authorised to collect your TFN under the Superannuation Industry (Supervision) Act 1993. We will treat it as confidential and only use it for lawful purposes. This includes disclosing it to another superannuation fund when we're arranging a transfer of funds for you. However, you may request in writing that your TFN not be disclosed to any other trustee.

☐ I understand the above statements and agree to provide my TFN.

I advise that my tax file number is: ___ ___ ___ ___ ___ ___ ___ ___ ___

Please note we will validate your TFN and personal details with the ATO and contact you if we cannot confirm your details.

SECTION 3. PAYMENT INSTRUCTIONS

Payment of your claim will be made in proportion to the value of your total investment options with CareSuper at the time of payment.

Select your cash payment amount (select ✔ an option)

☐ Maximum amount available

☐ **$**

BANK ACCOUNT DETAILS

CareSuper will only pay a lump sum into an individual or joint bank account which includes your name.

Account name

Bank name/financial institution

BSB

Account number

SECTION 4. AUTHORISATION AND DECLARATION

I authorise CareSuper to process my withdrawal request in accordance with my instructions.

Where the full balance of my account is to be paid from CareSuper, I authorise the termination of my membership and I release the Trustee from any further liability to me, my dependants or my Legal Personal Representative in respect of my membership in CareSuper.

RESIDENCY STATEMENT

I am an Australian or New Zealand citizen or an Australian permanent resident.

☐ Yes ☐ No

PRIVACY

I have read CareSuper's Privacy Policy at **caresuper.com.au/privacypolicy** and I understand how CareSuper intends to handle my personal information and acknowledge my personal information will only be used for the purposes specified. I consent to the collection and use of my personal information by the Trustee to establish and administer my claim on medical grounds.

☐ I authorise CareSuper to use or disclose any ID information provided to electronically match identity details against Government records or other identification sources. The identity match process may involve the use of the Australian Government's Document Verification Service and our third-party identity match provider.

I have read and agree to the above member declaration statements.

✕ _____

Member's signature

__ __ / __ __ / __ __ __ __

Date (DD/MM/YYYY)

_____

Full name

YOU MUST PRINT AND THEN SIGN THIS FORM

The form won't be valid if you don't sign and date it. (We cannot accept digital signatures.)

ONCE YOU'RE DONE

Return this completed form and any supporting documents to:

CareSuper
Locked Bag 20019
Melbourne VIC 3001

For more information call **1300 360 149**

CLAIM CHECKLIST

I have:

- ☐ Signed this form
- ☐ Attached my certified proof of identity
- ☐ Completed a **Change of details** form (if you've changed your name)
- ☐ Completed and attached doctor's and/or specialist's certificates for terminal illness (if not previously provided). Certification must be dated within the last 24 months
- ☐ Completed the residency statement in Section 4.

Save form | Print form | Clear form

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CareSuper

Terminal illness medical certificate

Complete this form in blue or black pen using BLOCK LETTERS and tick ✓ where applicable.

PERSONAL DETAILS

This section should be completed by you.

Member account number

Date of birth (DD/MM/YYYY)

Title

Surname

Given names

Residential address (required)

Suburb

State/territory

Postcode

Postal address (if different from above)

Suburb

State/territory

Postcode

Mobile

Daytime telephone

Email

DOCTOR'S DETAILS AND CERTIFICATIONS

This section should be completed by your doctor.

For a terminal illness claim, one of the doctors must be a specialist practising in a field related to the illness or injury suffered.

Doctor's surname

Given name

Provider number

Daytime telephone

Qualifications

Postal address

Suburb

State/territory

Postcode

CR/PERM/INCPT/CERT 748.9 05/23 ISS8

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

This section should be completed by your doctor.

DOCTOR'S STATEMENT AND CERTIFYING STAMP

(Select ✔ one option)

Terminal illness

In my opinion this person:

- ☐ **IS** suffering from a terminal illness which, in the normal course, would result in their death within 24 months of this certification.
- ☐ **IS NOT** suffering from a terminal illness which, in the normal course, would result in their death within 24 months of this certification.

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.

Please provide your original practitioner stamp to certify the following statement:

- ☐ I certify that the statement of diagnosis provided above is true and correct.

✕ _____

Signature

__ __ / __ __ / __ __ __ __

Date (DD/MM/YYYY)

_____

Full name

This certification must be made within the last 24 months.

Save form | Print form | Clear form

DOCTOR MUST PRINT AND THEN SIGN THIS FORM

Return this completed form to:

CareSuper
Locked Bag 20019
Melbourne VIC 3001

For more information call **1300 090 925**.

CareSuper

Terminal illness medical certificate (specialist)

Complete this form in blue or black pen using BLOCK LETTERS and tick ✓ where applicable.

PERSONAL DETAILS

This section should be completed by you.

Member account number

Date of birth (DD/MM/YYYY)

Title

Surname

Given names

Residential address (required)

Suburb

State/territory

Postcode

Postal address (if different from above)

Suburb

State/territory

Postcode

Mobile

Daytime telephone

Email

DOCTOR'S DETAILS AND CERTIFICATIONS

This section should be completed by your doctor.

For a terminal illness claim, one of the doctors must be a specialist practising in a field related to the illness or injury suffered.

Doctor's surname

Given name

Provider number

Daytime telephone

Qualifications

Postal address

Suburb

State/territory

Postcode

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

This section should be completed by your doctor.

DOCTOR'S STATEMENT AND CERTIFYING STAMP

(Select ✔ one option)

Terminal illness

In my opinion this person:

- ☐ **IS** suffering from a terminal illness which, in the normal course, would result in their death within 24 months of this certification.
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Please provide your original practitioner stamp to certify the following statement:

- ☐ I certify that the statement of diagnosis provided above is true and correct.

✕ _____

Signature

__ __ / __ __ / __ __ __ __

Date (DD/MM/YYYY)

_____

Full name

This certification must be made within the last 24 months.

Save form | Print form | Clear form

DOCTOR MUST PRINT AND THEN SIGN THIS FORM

Return this completed form to:

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