Member Super Facts

Making a TPD claim

did you know?

If you are permanently incapacitated but do not have TPD insurance, you may be able to receive the balance of your CareSuper account through a different process. Call the CareSuperLine on **1300 360 149** for more information.

Information helpline

For more information on CareSuper or super related topics call the CareSuperLine on **1300 360 149**, email **admin@caresuper.com.au** or visit **caresuper.com.au**

CARE Super Pty Ltd (Trustee)
ABN 91 006 670 060 AFSL 235226
CARE Super (Fund) ABN 98 172 275 725

We understand that the claims process may be a difficult time for you. The following information is intended to assist you and help you understand what to expect throughout the process.

What is TPD cover?

Total & permanent disablement (TPD) cover provides eligible insured members a lump sum payment (benefit) if it has been determined by the Trustee and the insurer that you are unlikely to ever be able to work again if you are employed at the time of disablement. If you have been unemployed for a continuous period of 12 months before the onset of the disability, the insurer will base their assessment on whether you are unable to perform at least two of the activities of daily living as described in the insurance policy. If eligible for the insurance benefit, you will also receive the account balance from your CareSuper account (there may be extra steps required for members invested in the Direct Investment option). You may elect to receive all or part of your TPD benefit as an income stream rather than as a lump sum payment.

How do I qualify for a TPD benefit?

You may qualify for a TPD benefit if you suffer (while insured) an illness or injury that meets the definition of total & permanent disablement as determined by our insurer in accordance with the policy.

The TPD definition used to assess your claim will be the insurance policy definition in place at the time of your disablement. Medical exclusions may apply to your cover (see your Insurance acceptance letter or call the CareSuperLine for details).

How long does it take to process a claim?

There are many rules governing claims and the release of your super, and the collection and review of comprehensive information (such as medical evidence) can make it a lengthy process. Along with the insurer we will strive to make the process as straightforward and fast as possible. All cases are unique, but generally most TPD claims can be resolved within 6 months of lodgement with the Fund.

The best way to ensure your claim is processed in a timely manner is to provide all of the required information and forms at the beginning of the process. If you have any questions or aren't sure how to complete any of the documentation, contact your dedicated case manager at CareSuper.

It's important that you keep us informed of any changes to your situation throughout the claims process.

Information on how to make a claim can be found over the page.

if you need assistance...

You always have a right to seek advice about an insurance claim, and in some circumstances an adviser or a lawyer may provide useful assistance. But using lawyers to help with more straightforward insurance claims could add unnecessary cost and complications. After all, we want you and your family or beneficiaries to receive the full insurance benefit.

We're always here to help

Our dedicated insurance specialists are experienced in helping members through the claims process and are available to give you professional and patient assistance. So remember that we're always here to help you with any questions you might have.

Continued

How do I make a claim?

The information below outlines the steps involved in submitting and assessing your claim.

1 Contact us to notify us of your claim

Please call the CareSuperLine on **1300 360 149** to speak to a member of our insurance team who will organise for the relevant initial documents to be sent to you including:

- A claimant's statement (to be completed by you)
- A medical attendant's statement (to be completed by your treating doctor)
- An employer's statement (to be completed by your most recent employer)
- Privacy consent forms.

You will need to meet any costs incurred in the completion or provision of any of the documents listed above.

2 Submit the claim

Once you have completed the claim forms and collected all of the initial requirements, send to CareSuper along with:

- A certified copy of your driver's licence or passport to provide proof of your age and identity
- Copies of any other medical reports or evidence that you have in support of your claim.

All documentation should be mailed to:

CareSuper
Locked Bag 5087
Parramatta NSW 2124

Please note: The insurer will not commence assessment of your claim until the waiting period has expired.

3 CareSuper check

Our claims team will review the information and check your eligibility to lodge a claim. This involves ensuring that you had insurance cover at the relevant time and that your insurance premiums have been paid for that period.

If there is any missing information, you will be contacted. Once this initial information has been received, we will submit your claim to our insurer for assessment.

4 Our insurer will assess your claim

Our insurer will assess your claim, including your eligibility to claim, in line with the insurance policy terms and conditions. Each claim is assessed on an individual basis. For the insurer to fully assess a claim additional information may be required including the following:

- Tax return and assessment notices
- Specialist medical reports
- Additional medical reports/documentation
- Independent medical examination
- Clinical records
- Workers' compensation records
- Centrelink records
- Pharmaceutical Benefits Scheme (PBS)/Health Insurance Commission (HIC) records
- Employer information e.g. payroll records, duties performed.

If any of these items are required our insurer will contact you.

There may be some cases where you are not eligible for benefits under the current insurance policy and the claim may therefore be referred to a previous insurer. Where this occurs, you will be advised at the time of assessment.

5 We will notify you of the decision

If your claim is accepted we will request instruction from you on how you would like the benefit paid.

In the event that you disagree with the insurer or Trustee's decision you will have an opportunity to lodge a complaint in writing. Further information on how to do this will be provided in your claim decision letter.

Please note that this information is a summary only. Further information can be found in your relevant **Member Guide PDS** and **Insurance Guide**.

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