

Please complete all the details on this form in **BLOCK LETTERS** using a **BLACK PEN** and return to Super SA via post or email.

You should complete this form if you have applied to change your cover using the "change my insurance" form and we asked you to attach this "personal health statement" to assess your application.

To find out more visit supersa.sa.gov.au or call (08) 8214 7800



1. Personal details	
Title	Date of birth
	D D / M M / Y Y Y Y
Given name(s)	
Family name	

2. Health information

1. Height (in cm)	Weight (in kg)		
2. Have you ever been approved a TPD/TI entitlement in any other SA government superannuation scheme? Yes No If Yes, you may not be entitled to insurance. (eg Triple S, Lump Sum, Pension Scheme, Super SA Flexible Rollover Product, Super SA Select, SA Ambulance Superannuation Scheme, SA Metropolitan Fire Service Super Scheme).			
3. Are you, or have you b If Yes	been, a smoker or used ¹ any sort of tobacco product ² in the last 5 years? Yes No		
What type(s) of tobac	cco product?		
What brand(s) of toba	acco product?		
How many times a day	y do you use a tobacco product? When did you first begin smoking? D D / M M / Y Y Y Y		
If you have ceased sm	noking within the last five years, when did you cease? D D / M M / Y Y Y Y		
4. Do you have an illness/medical condition(s) ³ or disability or symptoms that may indicate an illness? Yes No If No, please proceed to question 7.			
Has this been diagnos	sed by a medical practitioner? Yes No If Yes, when was the diagnosis? D D / M M / Y Y Y Y		
5. What is the exact nature of the illness/medical condition(s) ³ or disability? If more than one condition, please attach additional information.			
1 Lice of tobacco includes on	making chawing or sucking of a tobacco product or any other activity involving the consumption of a tobacco product		

ing of a tobacco product or any other activity involving the o includes smoking, chewing or suc nsumption of a tobacco product

2 A tobacco product means a cigarette, cigar, pipe tobacco, tobacco prepared for chewing or sucking, or snuff.

3 A "medical condition" is any disease, injury, disability, disability, syndrome, infection, behaviour and atypical variations of structure and function that impact on or affect the physical and/or mental condition, and impairs normal function.



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2. Health information (continued) 6. a) When did you first suffer from the above illness/medical condition(s) ³ or disability?		
b) Have you had any symptoms or recurrence arising from the illness/medical condition(s) ³ or disability? Yes No		
c) Is/are the illness/medical condition(s) ³ or disability getting worse? Yes No		
d) How many days have you been absent from your employment due to your illness/medical condition ³ in the last 12 months?		
7. a) Are you receiving treatment (including medication) for the illness/medical condition(s) ³ or disability? Yes No If Yes, please give details:		
b) What was the nature of any treatment?		
 8. a) Have you ever been diagnosed or consulted with, a medical practitioner in relation to a medical condition (including any symptoms that may have indicated a medical condition) or injury other than as listed above? If Yes, you are required to provide the following details: 		
b) What was the exact nature of the illness/medical condition(s) ³ or disability? If more than one condition, please attach additional information.		
c) When did you first suffer from the above illness/medical condition(s) ³ or disability?		
d) Have you had any symptoms or recurrence arising from the illness/medical condition(s)³ or disability?		

3 A "medical condition" is any disease, injury, disability, disorder, syndrome, infection, behaviour and atypical variations of structure and function that impact on or affect the physical and/or mental condition, and impairs normal function.



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2. Health information (continued) e) What was the nature of the treatment?			
 9. Have you ever had any surgical procedures in relation to any illness/medical condition(s)³ or disability? Yes No If Yes, please give details including dates: 			
10. Do you have any reason to believe that you will require medical advice or treatment in the next 6 months?YesNoIf Yes, please give details:			
11. Are you taking any medications? Yes No If Yes, please give details (e.g. medication name, dosage, how long have you been taking it for):			
Thes, please give details (e.g. medication name, dosage, now long have you been taking it jon).			
① This section must be completed in all cases			
12. Please provide the name(s) of doctor(s) for your most recent consultation due to all illnesses/medical condition(s) ³ or disability.			
Doctor's name:			
Doctor's address:			
Suburb State Postcode			
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2. Health information (continued)					
Practitioner 2				 	
Doctor's name:					
Doctor's address:					
Suburb				State	Postcode
Practitioner 3					
Doctor's name:					
Doctor's address:					
Suburb				State	Postcode

3. Member Declaration

- I understand that I am required to provide all information relating to medical advice, examination or treatment received by me and all information as to any illness/medical condition(s)³ or disability suffered by me, or any symptoms suffered by me that may indicate an illness/medical condition(s)³ or disability.
- I understand that I may have to provide additional medical evidence to support my application and I am responsible for any costs which may be incurred.
- I understand that I am required to disclose every matter that could reasonably be expected to be known by me, which may be relevant in Super SA's decision whether to accept the risk of insuring me.
- I understand that an insurance entitlement may be withheld (not payable) if the cause of my death or disability is caused wholly or partly by a preexisting illness/medical condition(s)³ or disability, or an illness/medical condition(s)³ or disability arising out of a pre-existing illness/medical condition(s)³ or disability, or a prescribed activity.
- I understand that non-disclosure will result in my insurance entitlement being withheld, reduced or declined.

- I understand that in most cases if I terminated public sector employment in connection with a voluntary separation package, I cannot claim a TPD benefit in relation to incapacity for work that was known to me at the time of termination.
- I authorise any hospital, doctor or other person who has treated or examined me to provide Super SA with any further information or medical reports on my illness/medical condition(s)³ or injury, medical history, consultations, prescriptions or treatment.
- I understand that Super SA and its medical adviser(s) will use this information for the purpose of considering my application for insurance. Super SA may approve, decline or accept an application subject to limitations.
- I have read and understood the relevant Product Disclosure Statement available on the Super SA website supersa.sa.gov.au.
- I understand that the cost of the insurance cover will be deducted from my account.
- I acknowledge providing false or misleading information is an offence under the Southern State Superannuation Act 2009.

Signature	×	Date D D / M M / Y Y Y Y

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OFFICIAL: SENSITIVE (when completed)