Permanent Incapacity Claim

HESTA for mercy super

COMPLETE SHADED SECTIONS

Please complete in BLOCK LETTERS using a BLACK or BLUE pen and ensure it is signed and dated.

To enable the Trustee to assess your claim as quickly as possible, please ensure all questions in this form are answered and you have included medical certificates (attached) from two treating doctors. Where TPD insurance cover is present this would be subject to a separate assessment by the Insurer based on the terms and conditions of the insurance policy.

For assistance call HESTA for Mercy on 1300 368 891 or email **insurance@hestaformercy.com.au.**

IMPORTANT: Complete ALL details. This is needed to validate your identity and get in touch if we have any questions.

1. Your personal details

Member Number

Your name (First name and surname)

Date of birth DD / MM / YYYY

Mobile or daytime telephone

Email

Residential address (required)

Suburb | State | Postcode

Postal address (if different from above)

Suburb | State | Postcode

2. Employment and Education Details

Please list all the occupations you have had during your working life. (Where you have had more than two occupations attach a separate sheet).

Occupation	Period from	To
	-	
	-	

What level of Education do you have? (e.g. secondary, tertiary – please provide details)

Please list any other skills, training, trades or licences you've obtained during your working life.

Please continue over page

3. Medical condition

Please describe the nature of the disablement that caused you to stop work and how it has prevented you from working. (if there's insufficient space please attach a separate sheet)

When did the symptoms of your medical condition first appear? DD / MM / YYYY

When did you first consult a doctor for this medical condition? DD / MM / YYYY

When did you permanently cease employment because of this medical condition? DD / MM / YYYY

Name of your last employer

4. Declaration

I have read and understood HESTA's Privacy Collection Statement which is available at **hestaformercy.com.au/privacy** or by calling 1300 368 891, and accept that the information on this form is true and correct to the best of my knowledge and belief. I consent to my personal information being collected and used by the Trustee for the ongoing administration of my membership by the fund administrator and other service providers.

I declare the information supplied by me in this application is correct.

Your signature

Date DD / MM / YYYY

Send your completed forms (including Medical Certificates) together with your proof of identity to:

HESTA for Mercy, PO Box 8334, Woolloongabba QLD 4102

Issued by H.E.S.T. Australia Ltd ABN 66 006 818 695 AFSL No. 235249, Trustee of HESTA ABN 64 971 749 321. This information is of a general nature. It does not take into account your objectives, financial situation or specific needs. You should look at your own financial position and requirements before making a decision. You may wish to consult an adviser when doing this. The target market determination for HESTA for Mercy products can be found at **hestaformercy.com.au/tmd** Before making a decision about HESTA for Mercy products you should read the relevant product disclosure statement (call 1300 368 891 or visit **hestaformercy.com.au** for a copy), and consider any relevant risks (**hestaformercy.com.au/understandingrisk).**

Permanent Incapacity Claim – Certificate of Medical Attendant

Note: Any charge for the completion of this form must be paid by the patient.

5. To be completed by your Medical Attendant

Member's name

Date of birth DD / MM / YYYY

Address

Suburb

State

Postcode

The member has applied to HESTA for Mercy for an early release of their superannuation benefit due to Permanent Incapacity. To enable us to consider this matter, we require completion of a medical certificate. If you are of the opinion this person is permanently incapacitated as defined below, please complete this form.

I certify that *(name of patient)*

is diagnosed as suffering from

and in my opinion **is unlikely, because of ill health (whether physical or mental) to ever engage in gainful employment for which they are reasonably qualified by education, training or experience.**

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 superannuation benefits.

The patient has been permanently incapacitated since: DD / MM / YYYY

Doctor's full name

Address

Suburb

State

Postcode

Mobile or daytime telephone

Medical Qualifications

Provider number

Doctor's signature

Date DD / MM / YYYY

Permanent Incapacity Claim – Certificate of Medical Attendant

HESTA for mercy super

Note: Any charge for the completion of this form must be paid by the patient.

5. (continued) To be completed by another Medical Attendant

Member's name

Date of birth DD / MM / YYYY

Address

Suburb

State

Postcode

The member has applied to HESTA for Mercy for an early release of their superannuation benefit due to Permanent Incapacity. To enable us to consider this matter, we require completion of a medical certificate. If you are of the opinion this person is permanently incapacitated as defined below, please complete this form.

I certify that *(name of patient)*

is diagnosed as suffering from

and in my opinion **is unlikely, because of ill health (whether physical or mental) to ever engage in gainful employment for which they are reasonably qualified by education, training or experience.**

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 superannuation benefits.

The patient has been permanently incapacitated since: DD / MM / YYYY

Doctor's full name

Address

Suburb

State

Postcode

Mobile or daytime telephone

Medical Qualifications

Provider number

Doctor's signature

Date DD / MM / YYYY