

## Confidential medical report on incapacity

Please print clearly in black ink.

### Notes to members

This report will assist your application for payment of a benefit or benefits on the grounds of incapacity/invalidity.

This report will be treated as confidential information, although we do reserve the right to disclose the information to medical consultants who may be involved in the assessment of your application. If required by law, we may be obliged to disclose the contents of this report to a court or tribunal.

### What do you need to do

- Make an appointment with a qualified and registered medical practitioner and ask them to complete the rest of this form.
- Pay all the costs associated with completing this form.

### Which scheme are you a member of?

SASS

SSS

PSS

### Member's details

Member number

Birth date (DD-MM-YYYY)

Given name/s

Family name

Work or Home Daytime contact telephone number

Normal occupation/Specific job title

Date employment ceased

Employer at that time

Signature

Date

#### If you need help with this form

Contact Customer Service between 8:30 am and 5:30 pm AEST from Mon–Fri on [DB 1300 130 094](tel:1300130094) or [SASS 1300 130 095](tel:1300130095) or [SSS 1300 130 096](tel:1300130096) or [PSS 1300 130 097](tel:1300130097) or email [enquiries@stc.nsw.gov.au](mailto:enquiries@stc.nsw.gov.au)

## Notes to medical practitioners

This report forms part of this member's application for payment of benefits on the grounds of incapacity and will be used to help determine benefit eligibility.

This report will be treated at all times with confidentiality, although we reserve the right to disclose the information to other medical practitioners and may be obliged under legislative provisions to disclose the contents to a court or tribunal.

### What do you need to do

- Complete all sections of this form comprehensively.
- Use extra pages if you need more space. At the top of each extra page write the member's name and member number.
- Return this form and any attachments to:

**State Super, PO Box 1229, Wollongong, NSW 2500**

## Medical practitioner's details

Name

Professional qualifications

Postal address

Suburb

State/Territory

Postcode

Daytime contact telephone number

## General medical report

This member has consulted with me since (DD-MM-YYYY)

Date of last consultation (DD-MM-YYYY)

This member's physical details (at last consultation)

Height (cms)

Weight (kgs)

Blood pressure

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# Report on incapacity

Any current incapacity for which you have treated this member.

  
  

The nature of symptoms, with time of onset, duration and progress.

  
  

The nature, date and effectiveness of any surgery.

  
  

The nature, dosage and effectiveness of prescribed medication.

  
  

The nature and effectiveness of any other treatment.

  
  

Dates and results of recent examinations.

  
  

Please attach relevant reports.

Present diagnosis.

  
  

Please provide any extra comments in an attached letter.

## Name of contact details of any specialist consulted

Name of specialist consulted & specialty

Contact telephone number

Date of last consultation

 -  - 

Name of specialist consulted & specialty

Contact telephone number

Date of last consultation

 -  - 

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## Your privacy

The information you provide in this form is collected on behalf of and held for State Super by the scheme administrator, Mercer Administration Services (Australia) Pty Ltd, in accordance with STC's Privacy Statement, the *Privacy and Personal Information Protection Act 1998 (NSW)* and the *Health Records and Information Privacy Act 2002 (NSW)*, under which you have rights of access and correction. Information you provide may be disclosed to lawfully authorised government agencies and third parties including the insurer or medical consultant who may be involved with the assessment of this application.

Personal medical information in relation to your application may also be obtained from a third party, such as a medical consultant. Access to this information may be restricted if the information that is provided poses a serious threat to your life or health.

For further information about privacy, contact Mercer by writing to:

PO Box 1229  
Wollongong NSW 2500

or visit

[www.statesuper.nsw.gov.au](http://www.statesuper.nsw.gov.au)

ABN 29 239 066 746  
SPIN SAS0101AU

## Opinion on incapacity

### Normal occupation

In my opinion, this member

- will never be able to be employed in his/her normal occupation due to this incapacity
- is still able to be employed in his/her normal occupation.

### Any paid employment

In my opinion, this member

- will never be able to be employed in any form of paid occupation due to this incapacity
- is still able to be employed in some form of paid occupation - examples are:

  
  

### Financial capacity

In my opinion, this member

- is unable to administer his/her own financial affairs due to this incapacity
- is still able to administer his/her own financial affairs.

Signature

Date (DD-MM-YYYY)

 -  - 

## Terminal medical condition - *Only complete this section if applicable*

I certify that this member

- is
- is not

suffering from an illness or an injury that is likely to result in their death within 24 months of the date of this certification.

Signature

Date (DD-MM-YYYY)

 -  - 

### Return the completed form to

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WOLLONGONG NSW 2500

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