STATE SUPER
SAS Trustee Corporation

SASS
FORM 433

Confidential personal statement

To be completed by scheme member and signed in front of a medical examiner

Please print clearly in black ink.

1. Personal details

Member number

Mr/Mrs/Ms/Miss/Dr

Male ☐ Female ☐

Birth date (DD-MM-YYYY)

Given name(s)

Family name

Residential address

Suburb State/Territory Postcode

Postal address (please include postcode)

Suburb State/Territory Postcode

Email address

Employer

Present occupation

Marital status

Details of your pension (*if applicable*)

If you have ever received any payment for workers compensation, state amount and reason.

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Contact Customer Service between 8:30 am and 5:30 pm AEST from Mon–Fri on **1300 130 095** or email **enquiries@stc.nsw.gov.au**

2. Personal health statement

1 Do you drink alcohol?

☐ Yes ☐ No

If *Yes*, in what daily amount?

2 Have you at any time taken, or are you now taking any drugs, tablets or pills on a regular basis?

☐ Yes ☐ No

If *Yes*, give details and indicate if therapy is current.

3 Do you smoke?

☐ Yes ☐ No

If *Yes*, what is your daily consumption of tobacco?

4 What is the present and general state of your health?

5 Has your weight altered during the last three years?

☐ Yes ☐ No

If *Yes*, give details.

Increase ☐☐☐ kg or decrease ☐☐☐ kg

6 When were you last X-rayed and what was the result?

7 Have you ever been treated for an anxiety state or any nervous condition whatsoever?

☐ Yes ☐ No

If *Yes*, give details.

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2. Personal health statement (continued)

8 During the last 5 years have you had any illness, accident or injury, medical examination, advice or treatment or any X-ray?

☐ Yes ☐ No

If yes, give particulars of each instance below.

Date	Illness, accident or injury, etc. Give details and date of recovery.	Name and address of doctor consulted (if any).

9 Do you have any defects in sight, hearing or speech?

☐ Yes ☐ No

If *Yes*, give details.

10 Have you ever had any of the following:

a)	asthma, tuberculosis, pleurisy (wet or dry), or any other lung complaint?	☐ Yes	☐ No
b)	high blood pressure, pain in the chest, or any heart complaint?	☐ Yes	☐ No
c)	rheumatic fever?	☐ Yes	☐ No
d)	indigestion, gastric ulcer, duodenal ulcer, or dysentery?	☐ Yes	☐ No
e)	epilepsy, fits of any kind?	☐ Yes	☐ No
f)	mental disorder, breakdown, anxiety or nervous condition?	☐ Yes	☐ No
g)	kidney or bladder disease, including renal colic or stone?	☐ Yes	☐ No
h)	diabetes; thyroid or glandular trouble?	☐ Yes	☐ No
i)	cancer or tumour of any type?	☐ Yes	☐ No
j)	ear discharge, hearing defect or sinus trouble?	☐ Yes	☐ No
k)	defects in sight?	☐ Yes	☐ No
l)	bleeding from lung, bowel, or kidney?	☐ Yes	☐ No
m)	hernia?	☐ Yes	☐ No
n)	venereal disease?	☐ Yes	☐ No
o)	dermatitis or other skin trouble?	☐ Yes	☐ No
p)	any other serious illness, accident or operation?	☐ Yes	☐ No

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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:

GPO Box 2181
Melbourne VIC 3001

or visit

www.statesuper.nsw.gov.au

ABN 29 239 066 746
SPIN SAS0101AU

2. Personal health statement (continued)

11 If you answered yes to any of parts a) to p) of Question 10, give details below, including

- full particulars, including duration of illness
- dates
- name and address of doctor consulted (if any).

12 Please fill in the following schedule of your family history.

	Living family members		Deceased family members			
	Age	State of health (if not good, state reason)	Age at death	Year of death	Cause of death (to be stated fully and exactly)	Duration of last illness
Father						
Mother						
Brothers						
Sisters						

3. Please sign here (in front of the medical examiner as witness)

I hereby declare that the above statements are correct and I understand that any statement falsely declared may disqualify me from the additional benefits to which I may otherwise become entitled.

I also understand that I may be required to authorise in writing any Medical Practitioner who has attended or examined me, or whom I have consulted, to disclose in writing at any time, all information concerning me which the Medical Practitioner may in any manner have acquired.

Signature

Date

- -

Witness (Medical examiner)

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STATE SUPER
SAS Trustee Corporation

SASS
FORM 433

CONFIDENTIAL MEDICAL REPORT

TO BE COMPLETED BY A MEDICAL EXAMINER

Report on the health, constitution, prospects of longevity and premature retirement because of ill health of *(include member name below)*:

1 Give the following measurements. If estimated, please add (est).

Height in cm

Weight in kg

Chest (insp) in cm

Chest (exp) in cm

If chest expansion is less than 5cm, please comment as to apparent cause.

2 Is there any abnormality in breathing or of the respiratory system to palpation, percussion or auscultation?

☐ Yes ☐ No

If *Yes*, give details.

3 Is there any abnormality in the heart sounds or rhythm?

☐ Yes ☐ No

If any murmurs are present, describe fully.

4 What is the blood pressure (auscultatory method)? *The diastolic level is to be taken at the cessation of all sound. The recumbent position should be used where possible.*

Systolic mm Hg

Diastolic mm Hg

If the first systolic reading is above 140 or below 100, or the diastolic above 90 or below 60, two further readings at 5 to 10 minute intervals are required.

Systolic mm Hg

Diastolic mm Hg

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5 Do you consider the heart and vascular system to be perfectly healthy?

☐ Yes ☐ No

If *No*, give details.

6 Is there a hernia present?

☐ Yes ☐ No

If *Yes*, describe fully and state whether a satisfactory truss is worn.

7 Examination of urine. *The urine should be passed in the presence of the examiner. If not, please state circumstances.*

8 For females: is there any evidence of pregnancy or of any abnormality of the reproductive organs?

☐ Yes ☐ No

If *Yes*, give details.

9 Do you consider the genito-urinary system to be normal and healthy?

☐ Yes ☐ No

If *No*, give details.

10 Is there any abnormal reflex or other evidence of disease of the brain, nerves or spinal cord?

☐ Yes ☐ No

If *Yes*, give details.

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11 Is there any defect in sight, hearing or speech?

☐ Yes ☐ No

If *Yes*, give details.

12 In cases of present or past ear discharge or deafness, state result of auriscopic examination.

13 Is there any sign of stress/depression/anxiety?

☐ Yes ☐ No

If *Yes*, give details and name of treating specialist if applicable.

14 Has the member at any time taken, or are now taking, any drugs, tablets or pills on a regular basis?

☐ Yes ☐ No

If *Yes*, give details and indicate if therapy is current.

15 From your knowledge of this member's medical history do you consider he/she has a greater than normal expectancy of: *(please comment if answer is yes)*

a) becoming disabled to the extent of not being able to carry out any remunerative occupation prior to 58 years of age:

☐ Yes ☐ No

If *Yes*, give details.

b) dying before 58 years of age:

☐ Yes ☐ No

If *Yes*, please give details.

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Summary (to cover prospects of longevity and premature retirement because of ill health)

A Do you consider any medical attendant's reports or any special tests are required?

☐ Yes ☐ No

If *Yes*, give details.

B Do you consider the examinee to be pre-disposed to any particular ailment or likely to require surgical operation?

☐ Yes ☐ No

If *Yes*, give details.

C Comment fully on any unfavourable features
a) in the personal history

b) disclosed by your medical examination

D Please indicate appropriate classification of health status:

☐ above average
☐ average
☐ below average

E Please provide copies of any supplementary reports from other doctors/specialists that you may have on file (written within the last 5 years).

Please sign here (to be completed by medical examiner)

Name and address for payment of fee *(please PRINT and please give postcode)*

Suburb | State/Territory | Postcode

Signature (Medical examiner)

Date (DD-MM-YYYY)

Mail direct to
State Super (SASS)

GPO Box 2181
MELBOURNE VIC 3001

immediately on completion of the examination.

SASS 433 08/2022

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