

# Income Protection Benefit Guide

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Including claim forms

Issued 1 March 2025

[qsuper.qld.gov.au](http://qsuper.qld.gov.au)

Australian Retirement Trust Pty Ltd ABN 88 010 720 840, AFSL 228975,  
Trustee for Australian Retirement Trust ABN 60 905 115 063

The logo for QSuper, featuring a stylized white 'Q' followed by the word 'Super' in a white sans-serif font.

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**We are passionate about helping our members during their time of need. We're committed to partnering with you throughout the insurance claims process to get the best outcome for everybody involved.**

## Your income protection insurance

Income protection pays you a benefit while you are temporarily unable to work due to illness or injury, and this is called your benefit period.

If you have an Accumulation account and your date of disablement is on or after 1 July 2023:

- for salary-based income protection cover, your monthly benefit will be the lesser of your salary IP cover amount (expressed as a monthly amount) or 87.75%<sup>1</sup> of your pre-disability income.
- for unitised income protection cover, your monthly benefit will be the lesser of the insured value of your units or 87.75%<sup>1</sup> of your pre-disability income. Each unit is worth \$500 of cover a month, including a contribution replacement benefit of \$72.65.
- please note periods of no pay may reduce your pre-disability income.

If you have a Defined Benefit account, your monthly benefit will be up to 75% of your previous 1 July salary.

### Your eligibility

You may be eligible to receive an income protection benefit<sup>2</sup> if you:

- Have been diagnosed with either a total and temporary disablement, or partial and temporary disablement (see below definitions), and
- Hold either a Defined Benefit account, or income protection insurance through your QSuper Accumulation account.

### If you have an Accumulation account

The details of definitions, limitations, and requirements can be found in the Insurance Guide, and we encourage all members to read this guide. The definitions listed below have been summarised from the exact wording used in the guide.

#### Salary IP cover amount

Means your income protection cover calculated at 87.75% of your insured salary. This includes a 12.75% contribution replacement benefit.

#### Total and temporary disablement

Means you are unable to perform the material and substantial duties of your work for a period of time, solely because of the same illness or injury that caused you to stop working.

#### Partial and temporary disablement

Means you are unable to perform some but not all of the material and substantial duties of your work for a period of time, solely because of the same illness or injury that caused the total and temporary disablement.

## Pre-disability income

Means the average gross monthly income earned over the 12 months immediately prior to your date of disablement (or over your most recent period of employment).

### If you have a Defined Benefit account

The details of definitions, limitations, and requirements can be found in the Defined Benefit Account Guide, and we encourage all members with a Defined Benefit account to read this guide.

## How to make an income protection claim

To make a claim for an income protection benefit, you need to provide information about your condition and occupation. This will enable us to assess your claim efficiently and accurately.

Our four income protection claim benefit forms are at the back of this guide. These need to be **completed in full** and returned to us.

- Income Protection Benefit Claim (Part A) – Member's Statement – you (or your power of attorney) need to complete this part
- Income Protection Benefit Claim (Part B) – Employer's Statement – your employer needs to complete this part
- Income Protection Benefit Claim (Part C) – Doctor's Statement – your doctor needs to complete this part
- Tax File Number Declaration (Part D) – you (or your power of attorney) need to complete this part.

You should also attach any relevant medical documents on your condition to your claim forms, such as doctor's reports or test results.

Please note that you need to cover any costs charged by your doctor to complete the Income Protection Benefit Claim (Part C) – Doctor's Statement form.

**Once the forms are complete and you have attached any relevant documents, you can:**

- Email the forms to us at [insuranceclaims@qsuper.qld.gov.au](mailto:insuranceclaims@qsuper.qld.gov.au) or
- Post the forms to us at:  
QSuper  
Insurance Operations  
GPO Box 200  
Brisbane QLD 4001

**If you need any help with completing the forms, please call us on 1300 360 750.**

<sup>1</sup> Includes a 12.75% contribution replacement benefit. A contribution replacement benefit is a payment made to your QSuper Accumulation account while you are receiving an income protection benefit. <sup>2</sup> QSuper Accumulation account death cover, total and permanent disability (TPD) cover, and income protection cover are provided through a group life insurance policy provided by ART Life Insurance Limited (ABN 79 607 345 853, AFSL 483057) ('ART Life'). ART Life Insurance is a registered life insurance company that is ultimately owned by Australian Retirement Trust Pty Ltd as trustee for Australian Retirement Trust.

## Overview of the claims process

Here's a quick rundown of exactly how the claims process works:

### 1 We receive your income protection claim

Please make sure you have submitted these four completed income protection benefit claim forms:

- A** Income Protection Benefit Claim (Part A) – Member's Statement
- B** Income Protection Benefit Claim (Part B) – Employer's Statement
- C** Income Protection Benefit Claim (Part C) – Doctor's Statement
- D** Tax File Number Declaration (Part D)



### 2 We assess your claim



Our aim is to assess your claim as quickly as possible. Once we receive all the necessary paperwork, we will allocate a dedicated claims manager who will contact you within 5 business days.

Your claim will be assessed against the terms and conditions applicable to the insurance you held at the date of your illness or injury.

This may include:

- Any exclusions or limitations
- Any pre-existing conditions.

#### Assessment timeframe

We aim to make a decision on all income protection claims within 2 months. If we are unable to make a decision on your claim within this timeframe, we will write to you to explain why.

We will want to understand your situation as a whole, including: your job demands, what activities you are capable of doing, and how you might need assistance to return to work. With a full understanding of your situation, we will be better able to support you.

#### Additional information

If we need to confirm additional information while we assess your claim, we will contact you. This extra information may include: payslips to confirm your pre-disability income, confirmation of leave history, details of a Workers' Compensation claim, and any medical reports. With your consent, we may disclose your personal information to:

- Your employer,
- Authorised service providers (e.g. external insurers and assessors), and
- Medical, health and wellbeing professionals.

Please note, we will cover the cost of any additional medical information we may require during the initial assessment of your income protection claim, separate to the Income Protection Benefit Claim (Part C) – Doctor's Statement.



## Your claim is approved

### Your claim is approved

Weekly benefit payments will be made to your nominated bank account as we work with you to support your recovery and your return to work, where possible.

### What happens next

We'll be in regular contact to keep up to date with your changing situation, and to ensure the support we provide suits your personal circumstances.

### We'll support you during your recovery back to health and work

From the start we'll be working with you, your employer, and treatment providers, to come up with a safe and sustainable return to work strategy that is tailored to your personal circumstances.

### Returning to work

As you recover from your illness or injury, we will work with you, your employer, and your treatment providers, to help ease you back into work with a graduated return to work program. When we get to this stage, your claims manager will work with you to ensure this transition meets your needs.



## Your claim is not approved

### Your claim is not approved

Once our insurer has assessed all the available information about your claim, Australian Retirement Trust Pty Ltd (Trustee) will review the decision.

- If the Trustee requires extra information or does not agree with our Insurer's decision, your claim will be sent back to your claims manager for reconsideration.
- If the Trustee agrees with the decision to decline your claim, your claims manager will advise you of the outcome and provide you with a statement explaining the reasons your claim has not been approved.

### What happens next

You will receive a statement from us which includes:

- The reason for our decision
- Copies of the documents and information we have used to make our decision
- The appeals process.

### What if I am not happy with the decision?

We understand not everyone will be happy with the decisions made about their claims. If you wish to lodge an appeal for review by Australian Retirement Trust, please contact us:

**Mail** Quality and Compliance, Operations QSuper  
GPO Box 200, Brisbane QLD 4001

**Phone** 1300 360 750

**Email** [qsuper@qsuper.qld.gov.au](mailto:qsuper@qsuper.qld.gov.au)

**In person** 266 George St, Brisbane

Sunshine Coast University Hospital, Ground Floor,  
Main Hospital Building, 6 Doherty Street, Birtinya

You will need to cover any costs to obtain medical reports to support your appeal.

If you are still not satisfied with the review decision, you can lodge a complaint with the Australian Financial Complaints Authority (AFCA). AFCA provides fair and independent financial services complaint resolution that is free to consumers. AFCA imposes time limits within which to lodge a complaint with them. You should act promptly or otherwise consult the AFCA website ([afca.org.au](http://afca.org.au)) to find out if or when the time limit relevant to your circumstances expires. Please contact AFCA directly on **1800 931 678** (free call) or by email: [info@afca.org.au](mailto:info@afca.org.au) or in writing to Australian Financial Complaints Authority, GPO Box 3, Melbourne VIC 3001 to ascertain your eligibility to lodge a complaint. You can also visit the AFCA website at [afca.org.au](http://afca.org.au) for further information.

## Keeping your Accumulation account insurance

It is important to make sure your current insurance cover does not lapse and cancel while we are assessing your claim. Your cover will be cancelled if we do not receive any money into your Accumulation account for 13 continuous months.<sup>1</sup>

You can prevent this from happening by permanently opting in to cover or by having money added to your account.

You can permanently opt in to your insurance cover by logging in to Member Online and selecting 'I want to permanently opt in to cover': [qsuper.qld.gov.au/optin](https://qsuper.qld.gov.au/optin)

If you would like some help reviewing or changing your cover, please call us on **1300 360 750**.

## How your benefit is paid

If your income protection claim is approved, payments will be made into your nominated bank, credit union, or building society account. We cannot pay benefits into a business, trust, or loan account. If you provide incorrect details, there could be a delay in your payment and we cannot accept responsibility for this.

Benefits will be paid to your bank account weekly. We will deduct PAYG tax from your weekly benefit. You will be provided with a PAYG payment summary as soon as possible after the end of the financial year to allow you to complete your tax return.

There may be financial or tax implications that relate to receiving an income protection benefit. You may wish to get independent financial advice about this.

For Accumulation account members, you will also receive a contribution replacement benefit paid weekly into your Accumulation account while you are receiving an income protection benefit. For more information see the Insurance Guide.

If you are in receipt of an income protection benefit with a 'five year' or 'to age 65' benefit period, that commenced prior to the start of the financial year, your income protection benefit will be indexed every year. Australian Retirement Trust only applies positive indexation.

## Ongoing eligibility

### Reviewing ongoing eligibility

Throughout your income protection benefit period, we will contact you for extra information to assess your ongoing eligibility for a benefit.

The information we ask for could include confirming your leave status, your current treatment plans, and understanding how you perform activities of daily living.

During your benefit period, we will also ask about your work situation, which could include your pre-disability duties and job demands. This information is used to assess how your illness or injury may impact your ability to return to work and your ongoing entitlement to benefits.

During your benefit period, we will work closely with you, your employer, and your healthcare providers to help identify possible work options in the short and long term. We do this to support you with suitable options for returning to work.

## What to do while receiving an income protection benefit

We are committed to partnering with you while on claim, so we ask you to keep in regular contact with your claims manager and your employer.

While you are receiving an income protection benefit, we might also ask you to:

- Get medical report forms or reports completed by your doctor or medical specialist
- Attend independent medical or other assessments
- Have an interview over the phone or in person with our staff or agent/s
- Participate in rehabilitation or return to work programs.

This helps us determine whether you remain eligible to continue to receive income protection payments.

**Please note:** While you are off work, you may need to make alternate arrangements for any regular payments that come out of your pay. This may include private health insurance premiums, salary sacrifice, or voluntary super contributions.

## Graduated return to work program

We are committed to partnering with you throughout the entire claims process – from when we start supporting you, through your recovery from your illness or injury, right through to when you are able to transition back to work.

We believe that:



Work is healthy and returning to work is an important part of the recovery process.



By focusing on your abilities, we can help you realise your greatest potential.



By working together with all stakeholders, we can achieve the best possible outcomes.



Efficient and transparent communication helps us tailor your program to your individual needs.

<sup>1</sup> There are various circumstances when cover will end, refer to the Insurance Guide, available at [qsuper.qld.gov.au/pds](https://qsuper.qld.gov.au/pds)

## What if my situation changes?

To make sure we pay you the right benefit, it's important you let your claims manager know as soon as possible if you:

- Return to work or start new employment
- Receive a benefit from another income protection, disability income, accident, or sickness policy
- Start an approved graduated return to work program
- Take any leave other than approved sick leave without pay (i.e. annual leave, recreational leave, long service leave, or parental leave)
- Earn additional income
- Have received Workers' Compensation benefits
- Receive a benefit or compensation from motor accident compensation, social security, or another legislated payment
- Receive any statutory or other government payments for loss of income relating to your illness or injury
- Engage in a new business, employment or occupation
- Cease to be an Australian resident or intend to reside outside of Australia for six (6) months or more.

If you don't let us know when your situation changes, you may receive an overpayment of benefits or an incorrect payment, which you will be required to repay.

There are several reasons we might reduce, offset, suspend, or stop paying your benefit, depending upon your insurance and the date your benefit commenced.

Full details can be found in the Insurance Guide, or Defined Benefit Account Guide, and we encourage all members to read the applicable guide.

## Claims checklist

- Make sure you read this guide, and either the Insurance Guide, or Defined Benefit Account Guide, before you complete the attached forms. Keep these guides somewhere handy in case you need to refer to them.
- It's important the forms are completed in full (including being signed and dated) before they are sent to us, or your claim could be delayed. Attach any necessary documents that support your claim.
- Check that you have completed the payment details section on the Income Protection Benefit Claim (Part A) – Member's Statement correctly, and that you have listed an account with an Australian bank, credit union, or building society. This will avoid any delays with payment.

If you require any assistance or have questions about making a claim or completing the forms, please call us on **1300 360 750**.

Forward your completed forms to us:

- Email us at [insuranceclaims@qsuper.qld.gov.au](mailto:insuranceclaims@qsuper.qld.gov.au)
- Post your forms to:
  - QSuper
  - Insurance Operations
  - GPO Box 200
  - Brisbane QLD 4001

**We value your security, and we recommend that you don't keep copies of sensitive information in your email account, Dropbox, or Google Drive, to protect yourself in the event your account or password are ever hacked.**

### Member Services team

Phone 1300 360 750  
Overseas +61 7 3239 1004  
Monday to Friday 8.00am – 6.00pm (AEST)

Postal address GPO Box 200, Brisbane QLD 4001  
Email [qsuper@qsuper.qld.gov.au](mailto:qsuper@qsuper.qld.gov.au)  
Fax 1300 242 070  
Website [qsuper.qld.gov.au](http://qsuper.qld.gov.au)

### Member Centres

Visit [qsuper.qld.gov.au/membercentres](http://qsuper.qld.gov.au/membercentres) for locations

This information and all QSuper products are issued by Australian Retirement Trust Pty Ltd (ABN 88 010 720 840, AFSL 228975) (Trustee) as trustee for Australian Retirement Trust (ABN 60 905 115 063) (Fund). Any reference to "QSuper" is a reference to the Government Division of the Fund. This is general information only, so it does not take into account your personal objectives, financial situation, or needs. You should consider whether the product is right for you by reading the relevant product disclosure statement (PDS). The PDS and the Target Market Determination (TMD) are available at [qsuper.qld.gov.au/PDS](http://qsuper.qld.gov.au/PDS) or call us on 1300 360 750 to request a copy. Where necessary, consider seeking professional advice tailored to your individual circumstances.

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# Income Protection Benefit Claim (Part A) – Member’s Statement

In order to assess your income protection claim efficiently and accurately, we need to gather information about your condition and occupation.

If you need any help in completing this form, please call us on **1300 360 750**. Please ensure you have answered all questions and signed and dated the form before you send it to us.

Please complete in BLOCK letters, using blue or black ink.

## 1 Personal information

Client number

You can find your client number on your annual statement, recent communications from us, or Member Online at [memberonline.qsuper.qld.gov.au](http://memberonline.qsuper.qld.gov.au)

Title

Given names

Surname

Previous name (if we know you by another name)

Date of birth (dd/mm/yyyy)

Home phone number

Mobile phone number

Email address

Residential address

State

Postcode

Postal address

As above

State

Postcode

Preferred method of contact

Email

Home phone

Mobile

## 2 Medical information

Please attach copies of any medical evidence you already have on your illness or injury, and any other relevant information.

Name of your illness or injury (please provide a detailed description)

What was the cause of your illness or injury?

When did you first see a doctor about your illness or injury? (dd/mm/yyyy)

When was your illness first diagnosed or when did your injury occur? (dd/mm/yyyy)

When did you stop working because of your illness or injury? (dd/mm/yyyy)

What duties are/were you prevented from doing?

Have you returned to work or started a graduated return to work (GRTW) program?

Yes  No

If **yes**, please specify the date you returned to work or the date your GRTW program started. (dd/mm/yyyy)



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### 3 Treatment information

Are you receiving, or are you willing to receive, appropriate medical care recommended by your treating medical practitioners?

Yes  No

What treatment are you currently receiving?

When did you start your treatment?

Date (dd/mm/yyyy)

Frequency (e.g. daily, weekly, monthly)

**Please provide your treating doctor's details below.**

Doctor's name

Doctor's phone number

Doctor's email address

Doctor's speciality (e.g. cardiovascular, neurology)

**Please provide any specialists or other treatment provider's details below.**

Name

Phone number

Email address

Speciality

### 4 Employment information

If you are self-employed and do not have any other employers, please go to section 6.

Name of your employer

Your employer's district/region

Payroll number

Your position/job title

What was your gross (before-tax) salary prior to your illness or injury?

Salary (before-tax)

 \$

Frequency (e.g. weekly, fortnightly)

Please describe your job in detail, including all of your duties and responsibilities, and attach a position description if possible.

### 5 Other Employment

If you receive a salary from any other employers, please provide details. If you are self-employed and do not have any other employers, please go to section 6.

Name of your employer

Payroll number

Salary (before-tax)

 \$

Frequency (e.g. weekly, fortnightly)

Employment start date (dd/mm/yyyy)

If you have more employers to list, please attach a list, providing these details for each employer.

**6 Self-employed information**

**Please complete this section only if you are self-employed.**

What income did **your business** earn in the last 12 months, as a direct result of your physical exertion or activity through your usual occupation?

<b>Gross income (before-tax)</b>	<b>Expenses</b>
\$ <input type="text"/>	\$ <input type="text"/>

What were your **personal** income and expenses for the last 12 months (pre-disability)?

<b>Gross income (before-tax)</b>	<b>Expenses</b>
\$ <input type="text"/>	\$ <input type="text"/>

**7 Other benefits and entitlements**

**Have you claimed, or do you plan to claim, a benefit from WorkCover for this illness or injury (workers’ compensation)?**

Yes  No

<b>Claim start date</b> (dd/mm/yyyy)	<b>Claim end date</b> (dd/mm/yyyy)
<input type="text"/>	<input type="text"/>

**WorkCover case manager’s name**

**WorkCover case manager’s phone number**

**WorkCover claim number**

**WorkCover payment amount (before-tax)**

**Frequency** (e.g. weekly, fortnightly)

**WorkCover lump sum benefits**

**Date paid** (dd/mm/yyyy)

**If you have received or are receiving an income from any other sources listed below, please let us know the income, frequency, date the payment started, and any lump sum payments received.**

**Services Australia** (e.g. Centrelink, Department of Veterans’ Affairs, etc.)

**Income amount (before-tax)**

**Frequency** (e.g. weekly, fortnightly)

<b>Start date</b> (dd/mm/yyyy)	<b>End date</b> (dd/mm/yyyy)
<input type="text"/>	<input type="text"/>

<b>Lump sum benefits</b>	<b>Date paid</b> (dd/mm/yyyy)
\$ <input type="text"/>	<input type="text"/>

**Another insurance policy**

**Insurance company name**

**Benefit payment amount (before-tax)**

**Frequency** (e.g. weekly, fortnightly)

**Benefit payment start date** (dd/mm/yyyy)

<b>Lump sum benefits</b>	<b>Date paid</b> (dd/mm/yyyy)
\$ <input type="text"/>	<input type="text"/>

**Other (please specify)**

Provide details of any other sources of income, including motor accident compensation, statutory payments, or other government payments.

**Details**

**Income amount (before-tax)**

**Frequency** (e.g. weekly, fortnightly)

<b>Start date</b> (dd/mm/yyyy)	<b>End date</b> (dd/mm/yyyy)
<input type="text"/>	<input type="text"/>

<b>Lump sum benefits</b>	<b>Date paid</b> (dd/mm/yyyy)
\$ <input type="text"/>	<input type="text"/>

If you need to list other sources of income, please attach a list, providing these details for each source of income.

**Have you ever made a claim for total and permanent disability or a terminal illness with us or any other body?**

Yes  No

## 8 Receiving your payment

We can only make payments into an Australian bank, credit union, or building society account that is in your name or a joint name. This means that payments cannot be made into a business, trust, or loan account.

Name of your bank, credit union, or building society

Branch (BSB) number

Account number

Account name

Please review the explanatory notes and the authorities on the following pages in full and sign and date as applicable before returning to us.

If you want to give us the authority to release information about your claim to your personal representative, such as your partner, please complete the *Disclosure Authority* form.

## Notes on releasing information about your health.

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

Our insurer<sup>1</sup> collects and uses your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent to obtain your health information, unless we reach a different agreement with you.

Please sign to accept both Authorities. Withholding your consent can result in delays and might mean we are unable to process your application or claim.

Before signing, please read each Authority carefully and the explanatory notes below.

**Authority 1 explanatory notes** – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

**Authority 2 explanatory notes** – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 20 business days from our request; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

**Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice**

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With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to the insurer, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form the insurer asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- Our insurer can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while the insurer is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed physically or electronically.

Name

Signature

Date signed (dd/mm/yyyy)

 /  /

## Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/ Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to the insurer, or to third parties they engage, only if the insurer has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within 20 business days; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- The insurer can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while the insurer is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed physically or electronically.

Name

Signature

Date signed (dd/mm/yyyy)

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## Your Privacy

### Personal information collection

The purpose for which we collect your information is to provide superannuation benefits, administer your benefits, and provide related services, information, and offers to you. This includes processing your application, managing your participation in Australian Retirement Trust, providing you with information about your benefits and our available services, and ensuring you receive your entitlements.

We will generally collect your personal information directly from you, your authorised representatives, your employer or other third parties, such as the Australian Taxation Office (ATO). If the information we request is not provided, we may be unable to properly administer your benefits and notify you about your entitlements.

We may disclose your personal information to entities within the Australian Retirement Trust Group, our service providers and advisers, medical and health professionals, regulators and government bodies, or to other third parties if we need to or if you have given consent to the disclosure. This includes but is not limited to the Fund's administration service provider, insurers, auditors and legal advisers. We also might be required by law to disclose information about you, for example to government bodies such as the ATO. We may also disclose information to third-party service providers in various countries, as described in our Privacy Policy.

For more information, please read our Privacy Policy which sets out the types of information we collect and how we collect, hold, use and disclose your personal information. Our Privacy Policy also describes how you can access information about your benefit and personal details, correct any information which is inaccurate or out-of-date, and information on our privacy complaints process. We are committed to respecting the privacy of personal information you give us. Our Privacy Policy may be updated from time to time and is available at [qsuper.qld.gov.au/privacy](https://qsuper.qld.gov.au/privacy) or by contacting us.

## Declaration and Authorisation

- I confirm that I am the member named on this form or I have power of attorney to act on the member's behalf and that the information given on this form is true and correct.
- I understand that my insurance will be cancelled if Australian Retirement Trust does not receive any money into my Accumulation account for 13 continuous months and I have not permanently opted in to cover.
- I understand and agree that I have an obligation to do all things reasonably necessary to assist the insurer to assess my claim and to investigate any matter in connection with my claim (for example, providing medical information and undertaking medical examinations or occupational assessments where requested). I understand that if I do not do all things reasonably necessary to assist with the assessment or investigation, Australian Retirement Trust or the insurer may not be able to assess my claim.
- I understand and agree that a photocopy of this document (including this Declaration and Authorisation) is considered as valid as the original.
- I have read the QSuper Product Disclosure Statement for Income Account and Lifetime Pension (PDS), the QSuper Product Disclosure Statement for Accumulation Account (PDS), the Accumulation Account Insurance Guide, and the Defined Benefit Guide (if applicable).
- I consent to Australian Retirement Trust and the insurer and their service providers collecting my personal, financial and medical information for the purpose of assessing and managing my claim or confirming the information provided when I applied for cover. This information may be collected from the individuals and organisations listed below:
  - My employer
  - My accountant
  - Workers' compensation insurer
  - CTP insurer, other insurers, and other superannuation funds
  - Federal and State Government agencies including Services Australia (e.g. Centrelink, Department of Veterans' Affairs, etc.) and the Australian Taxation Office (ATO)
  - Medical professionals including my doctors, specialists
  - Rehabilitation, allied health, and return-to-work professionals appointed by me, my employer, other insurers, or my lawyer.

- I consent to Australian Retirement Trust and the insurer and their service providers disclosing my personal, financial and medical information for the purpose of assessing and managing my claim or confirming the information provided when I applied for cover. This information may be disclosed to the individuals and organisations listed below:
  - My employer
  - Other service providers, advisers and assessors appointed by Australian Retirement Trust or the insurer to carry out functions to assist in managing my claim
  - Medical professionals including my doctors, specialists
  - Rehabilitation, allied health, and return-to-work professionals appointed by me, other insurers, or my lawyer.
- I understand and agree that in addition to the above, my personal, financial and medical information may be shared between entities that are ultimately owned by Australian Retirement when necessary (including to enable Australian Retirement Trust or the insurer to respond to requests for information).

Name

Signature



**Please sign in blue or black pen** – we do not accept electronic signatures on this form

Date signed (dd/mm/yyyy)

 /  / 

If you are signing this form under a power of attorney (POA) and you have not already given us a certified copy of your POA documentation, please attach it to this form.

### Where to send the completed form

Once you have completed this form and attached any necessary documents, you can:

- Email us at [insuranceclaims@qsuper.qld.gov.au](mailto:insuranceclaims@qsuper.qld.gov.au)
- Post your forms to:
  - QSuper
  - Insurance Operations
  - GPO Box 200
  - Brisbane QLD 4001

The information you have provided will be used to assess your benefit entitlement for insurance. You should keep a copy of your completed form and this guide, as you may want to refer to it in the future.

**Member Services team****Phone** 1300 360 750**Overseas** +61 7 3239 1004

Monday to Friday 8.00am – 6.00pm (AEST)

**Postal address** GPO Box 200, Brisbane QLD 4001**Email** [qsuper@qsuper.qld.gov.au](mailto:qsuper@qsuper.qld.gov.au)**Fax** 1300 242 070**Website** [qsuper.qld.gov.au](http://qsuper.qld.gov.au)**Member Centres**Visit [qsuper.qld.gov.au/membercentres](http://qsuper.qld.gov.au/membercentres)  
for locations

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This is general information only, so it does not take into account your personal objectives, financial situation, or needs. Before acquiring or continuing to hold any financial product, you should consider whether the product is right for you by reading the relevant product disclosure statement (PDS). The PDS and Target Market Determination (TMD) for QSuper products are available at [qsuper.qld.gov.au/pds](http://qsuper.qld.gov.au/pds) or call us on 1300 360 750 to request a copy. Where necessary, consider seeking professional advice tailored to your individual circumstances.

We take protecting the privacy of personal information seriously. We are collecting your personal information to assess or manage your insurance application, cover or claim and to administer your superannuation account. We may also disclose this information to your employer, authorised service providers (such as external insurers and assessors), medical, health and wellbeing professionals, and other third parties if we need to, if you have given consent to the disclosure, or if we are required to by law. If you want to know more about our privacy policy, including how we collect, hold, use and disclose personal information, or how individuals can access or correct their information, visit [qsuper.qld.gov.au/privacy](http://qsuper.qld.gov.au/privacy) or call us to request a copy.

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# Income Protection Benefit Claim (Part B) – Employer’s Statement

Your employee is making a claim for an income protection benefit payment. This section of the claim form needs to be completed by your HR or payroll office staff. Please ensure you have answered all questions before you send it to us.

## 1 Employee information

Title	Given names
<input type="text"/>	<input type="text"/>
Surname	
<input type="text"/>	
Date of birth (dd/mm/yyyy)	Payroll number
<input type="text"/>	<input type="text"/>
Position/job title	
<input type="text"/>	
Place of employment and region	
<input type="text"/>	

## 2 Salary information

Please provide your employee’s remunerated salary, upon which the superannuation contribution is calculated.

If your employee works part-time, please provide us with their full-time salary and indicate their part-time ratio in section 3.

What was your employee’s full-time salary at 1 July before they went on sick leave without pay (SLWOP)?

Date (1 July yyyy)	Salary
<input type="text"/>	\$ <input type="text"/> per fortnight

What was your employee’s full-time salary prior to starting sick leave?

Date (dd/mm/yyyy)	Salary
<input type="text"/>	\$ <input type="text"/> per fortnight

What was the employer-paid superannuation guarantee (SG) contribution rate for your employee?

 %

Is your employee paying child support?

Yes  No

## 3 Employment information

Does your employee work:

Full-time

Part-time

p/t fortnightly ratio:

Casual

Contractor

Contract end date (dd/mm/yyyy):

Substantive weekly hours:

When did your employee last attend work? (dd/mm/yyyy)

When did they start sick leave? (dd/mm/yyyy)

What date was/will all accrued sick leave be exhausted? (dd/mm/yyyy)

Has your employee received other paid leave since all accrued sick leave was exhausted?

Yes  No

If yes, what date does this cease? (dd/mm/yyyy)

Has your employee taken sick leave without pay (SLWOP)?

Yes  No

If yes, provide dates:

SLWOP start (dd/mm/yyyy)	End (dd/mm/yyyy)
<input type="text"/>	<input type="text"/>

Employer rehabilitation contact name

Phone number

Email address

Preferred method of contact?

Email  Phone

Who else, apart from the employer rehabilitation contact listed above, should be advised upon assessment of this claim?

Name/s

Position/job title

Phone number

Email address



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Australian Retirement Trust Pty Ltd (ABN 88 010 720 840, AFSL 228975)  
is the trustee of Australian Retirement Trust (ABN 60 905 115 063).

#### 4 Additional comments

Please supply any information that clarifies or supports this statement.

#### 5 Employer information

Name of employer

Full name of authorised officer

Position held

Phone number

Email address (not generic email address)

Date statement completed (dd/mm/yyyy)

#### Additional information about this form

Your employee has authorised for you, the employer, to provide to Australian Retirement Trust, its service providers or its insurers their personal and medical information for use in assessing and managing their claim for an insurance benefit.

Please ensure you complete all the sections in the employer's statement before returning this form to us promptly.

This will assist us to progress the assessment of your employee's claim for an income protection benefit.

If your employee's situation changes (e.g. if they change the type of leave they take, if they start working again, or if their employment is terminated), please call us on **1300 360 750** or email us at **insuranceclaims@qsuper.qld.gov.au**

#### Where to send the completed form

Once you have completed this form, please email us at **insuranceclaims@qsuper.qld.gov.au**

#### Member Services team

Phone 1300 360 750

Overseas +61 7 3239 1004

Monday to Friday 8.00am – 6.00pm (AEST)

Postal address GPO Box 200, Brisbane QLD 4001

Email [qsuper@qsuper.qld.gov.au](mailto:qsuper@qsuper.qld.gov.au)

Fax 1300 242 070

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# Income Protection Benefit Claim (Part C) – Doctor’s Statement

Your patient is making a claim for an income protection benefit payment. This section of the claim form needs to be completed by their treating doctor, and we will use this information to assess your patient’s eligibility for income protection benefits.

Note that your patient will need to cover any costs your practice charges to complete this form.

If you have any questions in completing this form, please call us on **1300 360 750**. Please ensure you have answered all questions and signed and dated the form before you send it to us.

Make sure you complete this form in full, so that your patient’s claim is not delayed.

## 1 Patient information

Title  Given names

Surname

Date of birth (dd/mm/yyyy)

## 2 Treating doctor information

Please provide your details below.

Name

Speciality (e.g. cardiovascular)

Practice name

Phone number

Email address

Postal address

State  Postcode

Are you this patient’s usual doctor?

Yes  No

If **yes**, what date did you first begin treating this patient?  
(dd/mm/yyyy)

When was the patient’s last appointment with you?  
(dd/mm/yyyy)

If **no**, please provide details of the patient’s usual doctor.  
Name

Speciality  Practice name

Phone number

Email address

Postal address

State  Postcode



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### 3 Medical information

Based on your objective clinical findings, please confirm the patient's diagnosis.

Please describe your objective findings that support the diagnosis. (e.g. If condition is a mental illness, provide criteria as per DSM-V; if condition is musculoskeletal, provide ROM and strength test results.)

Please outline the patient's initial symptoms relating to this condition.

When did the patient's symptoms for this condition first occur? (dd/mm/yyyy)

Have the patient's symptoms changed in frequency or severity?

Yes  No

If yes, please describe how:

Has the patient ever experienced these symptoms, or similar symptoms, previously?

Yes  No

If yes, from when? (dd/mm/yyyy)

Please provide details:

Has your patient been unable to work due to the injury or illness?

Yes  No

If yes, from what date? (dd/mm/yyyy)

If no, please provide details:

What do you believe is the expected duration of illness or injury? (e.g. 1 month, 1 year, 10 years)

Date patient returned to work or expected to return to work (if known) (dd/mm/yyyy)

Does your patient have an additional diagnosis?

Yes  No

If yes, please describe:

What are the symptoms for the additional diagnosis?

Does the additional diagnosis present a barrier to your patient's return to work?

Yes  No

If yes, please provide details:

How was the patient's illness or injury caused?

By an accident

At their place of work

Neither

Please provide details:

Was the patient hospitalised?

Yes  No

If yes, please provide details and date of hospitalisation:

#### 4 Treatment information

**What active treatment (e.g. physiotherapy, surgery, counselling, medication) has the patient received from you and other practitioners since their illness or injury was diagnosed?**

##### Nature of treatment

Date referred (dd/mm/yyyy)

Frequency of treatment

Effectiveness of treatment

##### Medication name

Dosage and frequency

Date prescribed (dd/mm/yyyy)

Effectiveness of medication

##### Medication name

Dosage and frequency

Date prescribed (dd/mm/yyyy)

Effectiveness of medication

If your patient is taking any additional medications, please outline details, including medication name/s, dosage and frequency, date/s prescribed and effectiveness of medication/s.

Is there any additional treatment that would help improve the patient's functional capacity?

Yes  No

If **yes**, please provide details:

Have any tests or investigations been done to date?

Yes  No

If **yes**, please provide details.

**Please attach copies of test results where applicable (e.g. MRI, X-ray, ultrasound, blood test, ECG).**

Has your patient been referred to any consultants or specialists?

Yes  No

If **yes**, please provide details below.

Name

Speciality

Practice name

Address



State

Postcode

Phone number

Date of first appointment (dd/mm/yyyy)

Name

Speciality

Practice name

Address



State

Postcode

Phone number

Date of first appointment (dd/mm/yyyy)

Has the patient ever declined or deferred treatment?

Yes  No

If **yes**, please provide reasons.

When do you expect the patient would be cleared to return to work, including via a graduated return to work program?

If the patient is not responding to treatment or there are delays in accessing treatment, would you appreciate input from an independent medical specialist?

Yes  No

**5 Patient's functional capacity**

What is your understanding of the patient's occupation and their duties?

**Physical functional capacity**

For duration, please indicate whether the capacity or incapacity is temporary (T) or permanent (P).

Function	Able	Unable	Able with modifications	Duration (T/P)
Sit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	T <input type="radio"/> P <input type="radio"/>
Stand/Walk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	T <input type="radio"/> P <input type="radio"/>
Bend	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	T <input type="radio"/> P <input type="radio"/>
Squat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	T <input type="radio"/> P <input type="radio"/>
Kneel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	T <input type="radio"/> P <input type="radio"/>
Lift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	T <input type="radio"/> P <input type="radio"/>
Drive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	T <input type="radio"/> P <input type="radio"/>
Reach above shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	T <input type="radio"/> P <input type="radio"/>
Use injured limb	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	T <input type="radio"/> P <input type="radio"/>
Move neck	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	T <input type="radio"/> P <input type="radio"/>

Please provide additional comments on any capacity restrictions listed above:

**Mental health functional capacity**

For duration, please indicate whether the capacity or incapacity is temporary (T) or permanent (P).

Function	Not affected	Affected	Duration (T/P)
Attention/ Concentration	<input type="radio"/>	<input type="radio"/>	T <input type="radio"/> P <input type="radio"/>
Memory (short-term and/ or long-term)	<input type="radio"/>	<input type="radio"/>	T <input type="radio"/> P <input type="radio"/>
Judgement (ability to make decisions)	<input type="radio"/>	<input type="radio"/>	T <input type="radio"/> P <input type="radio"/>
Workplace stress (resilience/ability to cope)	<input type="radio"/>	<input type="radio"/>	T <input type="radio"/> P <input type="radio"/>

Please provide additional comments on any capacity restrictions listed above:

Other functional capacity considerations:

Comments
Effects of medication <div style="border: 1px solid black; height: 50px; width: 100%;"></div>
Work environment, e.g. physical impact (noise, space, light) or mental health impact <div style="border: 1px solid black; height: 50px; width: 100%;"></div>

## 6 Declaration

The information I have provided in this form is true and correct at the time of completion.

Name

Signature



**Please sign in blue or black pen** – we do not accept electronic signatures on this form

Date (dd/mm/yyyy)

 /  / 

### Where to send the completed form

Once you have completed this form and attached any necessary documents, please send it to us without delay:

- Email us at [insuranceclaims@qsuper.qld.gov.au](mailto:insuranceclaims@qsuper.qld.gov.au)
- Post your form to:
  - QSuper
  - Insurance Operations
  - GPO Box 200
  - Brisbane QLD 4001

Your patient has authorised for you and your agents, to provide to Australian Retirement Trust, its service providers or its insurers their personal and medical information for use in assessing and managing their claim for an insurance benefit.

#### Member Services team

Phone 1300 360 750  
Overseas +61 7 3239 1004  
Monday to Friday 8.00am – 6.00pm (AEST)

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# Tax File Number Declaration (Part D)

## When to use this form

Please complete and sign as the PAYEE and return to the PAYER, Australian Retirement Trust. For help completing this form visit the ATO website at [ato.gov.au](http://ato.gov.au)

Please complete in **BLOCK** letters, using blue or black ink.

### 1 What is your Tax File Number (TFN)?

Tax File Number

The ATO and your payer are authorised by the *Taxation Administration Act 1953* to request your TFN. It's not an offence not to quote your TFN. However, quoting your TFN reduces the risk of administrative errors and having extra tax withheld. Your payer is required to withhold the top rate of tax from all payments made to you if you do not provide your TFN or claim an exemption from quoting your TFN.

### 2 What is your name?

Title First name

 

Last name

Other given names

### 3 What is your home address in Australia?

Address

State  Postcode

### 4 If you have changed your name since you last dealt with the ATO, show your previous name details

Title First name

 

Last name

Other given names

### 5 What is your primary email address?

Email Address

### 6 What is your date of birth?

Date of birth (dd/mm/yyyy)

### 7 On what basis are you paid?

- Full-time employment
- Part-time employment
- Casual employment
- Labour hire
- Superannuation or annuity income stream

### 8 I am (select only one):

- An Australian resident for tax purposes
- A foreign resident for tax purposes
- A working holiday maker

### 9 Do you wish to claim the tax-free threshold from this payer?

Only claim the tax-free threshold from one payer at a time, unless your total income from all sources for the financial year will be less than the tax-free threshold.

Answer **No** here if you are a foreign resident or working holiday maker, except if you are a foreign resident in receipt of an Australian Government pension or allowance.

- Yes  No



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**10** Do you have a Higher Education Loan Program (HELP), VET Student Loan (VSL), Financial Supplement (FS), Student Start-up Loan (SSL) or Trade Support Loan (TSL) debt?

Yes  No

Answer **Yes** if you have a HELP, VSL, FS, SSL or TSL debt.

Answer **No** if you do not have a HELP, VSL, FS, SSL or TSL debt, or you have repaid your debt in full.

You have a HELP debt if either:

- The Australian Government lent you money under HECS-HELP, FEE-HELP, OS-HELP, VET FEE-HELP, VET Student loans prior to 1 July 2019 or SA-HELP.
- You have a debt from the previous Higher Education Contribution Scheme (HECS).

You have a SSL debt if you have an ABSTUDY SSL debt.

You have a separate VSL debt that is not part of your HELP debt if you incurred it from 1 July 2019.

For information about repaying your HELP, VSL, FS, SSL or TSL debt, visit [ato.gov.au/getloaninfo](http://ato.gov.au/getloaninfo)

**11** Declaration by payee

I declare that the information I have given is true and correct.

Signature



**Please sign in blue or black pen** – we do not accept electronic signatures on this form

Date signed (dd/mm/yyyy)

 /  / 

*Please note: There are penalties for deliberately making a false or misleading statement.*

**Where to send this form**

Please send your completed form to us by:

**Post**

QSuper  
GPO Box 200  
Brisbane QLD 4001

**Email**

[insuranceclaims@qsuper.qld.gov.au](mailto:insuranceclaims@qsuper.qld.gov.au)

**Member Services team**

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#### Phone

**1300 360 750** (+617 3239 1004 if overseas)

Monday to Friday: 8.00am – 6.00pm (AEST)

#### Email

[qsuper@qsuper.qld.gov.au](mailto:qsuper@qsuper.qld.gov.au)

#### Postal address

GPO Box 200, Brisbane QLD 4001

#### Fax

1300 241 602 (+617 3239 1111 if overseas)

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