Permanent Disability Benefit Guide

(including total and permanent disability (TPD) claim forms)

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qsuper.qld.gov.au

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Your total and permanent disability (TPD) insurance

At QSuper, we are passionate about helping our members during their time of need, and partnering with them throughout their insurance claims process. We know this will help to get the best outcome for everybody involved.

When am I eligible?

If you have suffered an illness or injury that permanently prevents you from working, you may be eligible for a TPD benefit.[1]

Accumulation account members

For more information on Accumulation account insurance definitions, limitations, and requirements, please read our *Accumulation Account Insurance Guide* available at **qsuper.qld.gov.au/pds** or call us to request a copy.

Defined Benefit members

For more information on Defined Benefit account insurance eligibility, please read our *Defined Benefit Account Guide* available at **qsuper.qld.gov.au/guides** or call us to request a copy.

How to make a TPD claim

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

At the back of this guide is our TPD claim form, which has three parts that will need to be completed in full and returned to QSuper:

- Member's Statement (Part A) – you (or your power of attorney) need to complete this section
- Employer's Statement (Part B) – your employer needs to complete this section
- Doctor's Statement (Part C) – your doctor needs to complete this section.

When you submit your completed application, please also attach copies of any relevant medical documents you already have relating to your condition, such as doctor's reports and test results.

Please note that you will need to cover any costs charged by your doctor to complete Part C of the claim form (Doctor's Statement).

Accessing your superannuation

If you have an injury or illness that permanently prevents you from working, but don't have total and permanent disability (TPD) insurance, you may be able to access your superannuation early. Complete the TPD claim form at the back of this guide, and we will assess your eligibility to withdraw your superannuation.

Once the forms are complete and you have attached any relevant documents, please return them to us by:

- Email: **insuranceclaims@qsuper.qld.gov.au**
- Post:

  QSuper
  Insurance Operations
  GPO Box 200
  Brisbane QLD 4001
- Fax: **07 3239 1139**
- In person at one of our Member Centres:

  70 Eagle Street Brisbane

  63 George Street Brisbane

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

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

How we assess your claim

Our aim is to assess your claim as quickly as possible. Once we receive all the necessary paperwork, a dedicated claims manager will be allocated to help you.

Your claims manager will contact you to:

- Talk you through the claims process
- Clarify any questions we have about the information supplied
- Answer any questions you might have about your claim.

If we need further medical information about you, we might ask you to provide a medical report about your medical history (note this is separate to the Doctor's Statement (Part C) of your initial claim). We will cover any costs to obtain this additional medical information.

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

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

If your claim is not approved, we will send you a letter explaining the reasons for our decision. If you are unhappy with our decision, you will find details of what you can do in the review and appeal process section of this guide.

What if I am receiving an income protection benefit?

An income protection benefit is payable if you're temporarily unable to work due to an illness or injury. If you become permanently disabled, your income protection benefit eligibility may change, depending on your insurance cover. Your claims manager will discuss this with you.

1 QSuper Accumulation account death cover, total and permanent disability (TPD) cover, and income protection cover are provided through a group life insurance policy issued to the QSuper Board by QInsure Limited (ABN 79 607 345 853, AFSL 483057) ('QInsure'). QInsure is ultimately owned by the QSuper Board as trustee for QSuper.

What if I have a terminal illness?

A terminal illness for insurance purposes is when your illness or injury is likely to result in death within a period of not more than 24 months. This prognosis will take into account reasonable medical treatment.

Accumulation and Defined Benefit account members

For more information on the terminal illness definitions, limitations, and requirements, please read our *Accumulation Account Insurance Guide* or *Defined Benefit Guide* available at **qsuper.qld.gov.au/guides** or call us to request a copy.

What if I do not have any death cover?

Please read our *Claiming a Terminal Medical Condition Benefit* factsheet for more information regarding your options available at **qsuper.qld.gov.au/factsheets**

State and Police accounts

If you have a State or Police account and you are diagnosed with a terminal illness, please call us on **1300 360 750** for information about your options.

How do I know what cover I have?

You can check how much insurance cover you have by:

- Logging in to Member Online at **memberonline.qsuper.qld.gov.au** and selecting 'Insurance' then 'Your Insurance'
- Call us on **1300 360 750**.

Please remember that your insurance benefit is calculated at your date of disablement.

Keeping your Accumulation account insurance

It is important to make sure your current Accumulation 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.[1]

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 select 'I want to permanently opt in to cover': **qsuper.qld.gov.au/optin**

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

What are my options if my claim is approved?

If your TPD claim is approved, you have a number of options for your benefit:

Accumulation account holders

Your benefit will be paid into your Accumulation account and you can choose one or any combination of the following:

- Leave your benefit in your Accumulation account and make lump sum withdrawals from your super when you need to.
- Open an Income account, which enables you to receive a regular income stream and make lump sum withdrawals as needed.
- Withdraw your benefit as cash.

Please be aware that there are potential tax considerations when withdrawing from your account and when setting up an Income account. For more information on this and other important considerations please contact us on **1300 360 750**.

Please read our *Accumulation Account Insurance Guide* for further information about your options.

Defined Benefit account holders

55 years of age and older

If you are 55 or older, your benefit will be transferred to an Accumulation account once you have ceased employment. You can then choose one or a combination of the options listed above for Accumulation account holders.

Under 55 years of age

If you are under the age of 55, your benefit will be transferred as a lump sum to an Accumulation account.

You will also have the option to receive a lifetime pension instead of the lump sum. You will need to tell us if you are taking this option within three months from the time you are determined as totally and permanently disabled, and before your funds are transferred to an Accumulation account.

Please read our *Defined Benefit Account Guide* for further information about your options.

If you have any questions regarding your benefit, please call us on **1300 360 750**.

State and Police accounts

If you have a State or Police account, please read our *State Account Guide or Police Account Guide* available at **qsuper.qld.gov.au/guides**

Advice options

A financial adviser may be able to help you decide the best way to deal with your superannuation benefits. See our website for more information about advice options **qsuper.qld.gov.au/financial-advice**

1 There are various circumstances when cover will end, refer to the *Accumulation Account Insurance Guide*, available at qsuper.qld.gov.au/pds

Enquiries and complaints

If you have a complaint, we want to resolve this for you as soon as possible, so please call us on **1300 360 750** (or +617 3239 1004 if calling from overseas).

Alternatively, write to us at:

The Enquiries and Complaints Officer
QSuper, GPO Box 200, Brisbane QLD 4001

Letters should be marked `Notice of enquiry or complaint'.

You can also email QSuper via the Contact us form on our website or visit one of our member centres.

If you are unhappy with our response, or if you have not received a response within the required period, 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 can contact AFCA by:

Phone: 1800 931 678 (free call)
Mail: Australian Financial Complaints Authority Limited, GPO Box 3 Melbourne, VIC 3001
Website: afca.org.au
Email: info@afca.org.au

Claims checklist

- Make sure you read this *Permanent Disability Benefit Guide* before you complete the attached forms.
- For members with an Accumulation account, please read the *Accumulation Account Insurance Guide*.
- For members with a Defined Benefit account, please read the *Defined Benefit Account Guide*.
- 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. Please attach any necessary documents that support your claim when sending us your forms.

We suggest keeping copies of your completed claim form and this guide somewhere easily accessible in case you need to refer to them.

At QSuper, we value your security and recommend that you do not keep copies of sensitive information in your email account or cloud storage service (e.g. Dropbox, or Google Drive), to protect yourself in the event your account or password are ever compromised.

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

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Total and Permanent Disability (TPD) Benefit Claim

(Part A) – Member's Statement

To apply for a TPD benefit, you need to provide us with information about your condition and occupation, as this helps us to assess your claim efficiently and accurately. We know the application process for a TPD benefit can seem overwhelming and we are here to help you. If you have any questions when 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**

Title **First name**

Last name

Previous name[1] (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

☐ **Personal email** (please provide below)

☐ **Home phone number** ☐ **Mobile phone number**

1 If your name has changed and you work for the Queensland Government or a default employer, let your payroll office know and they will let us know. Otherwise, please send us a certified copy of either a marriage certificate or other legal change of name document.

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 did you first start to experience signs or symptoms? (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)

/ /

Have you suffered from a similar illness or injury previously?

◯ Yes ◯ No

If **yes**, please provide details and dates

3 Treatment information

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

◯ Yes ◯ No (go to question 4)

If **yes**:
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)

Date first contacted (dd/mm/yyyy)
/ /

Date last contacted (dd/mm/yyyy)
/ /

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

Phone number

Email address

Speciality

Date first contacted (dd/mm/yyyy)
/ /

Date last contacted (dd/mm/yyyy)
/ /

If you have consulted other doctors, specialists or health professionals about your illness or injury, please provide their details separately, and attach it to your application form.

4 Employment information

Please attach a resume or a list of your previous jobs, including the position you held, your employer, the start and end dates (approximate), duties and responsibilities, for the past 10 years.

Employment status:

◯ Full time ◯ Part-time
◯ Casual ◯ Self-employed
◯ Other (including unemployment)

If **other** or **unemployed**, please provide details.

Name of your most recent employer

District/region

Payroll number

Your position/job title

Please describe your job in detail, including all of your duties and responsibilities, and attach a position description if possible. If your role involves manual handling duties (lifting, carrying, pushing, pulling) please provide details of these specific duties.

Are you still employed?

◯ Yes ◯ No

If **no**, did you terminate your employment due to any illness or injury?

◯ Yes ◯ No

Please provide the exact date of termination?
(dd/mm/yyyy)
/ /

Employer

Do you plan to return to work?

◯ Yes ◯ No

If **no**, please provide details.

Have you been able to work in any job, full-time, part-time, paid or unpaid, since your illness or injury?

◯ Yes ◯ No

If **yes**, please provide details.

Have you ceased all work and been certified in writing by a Medical Practitioner as unable to work due to your injury or illness?

◯ Yes ◯ No

If **yes**, who provided certification and on what date did this occur?

Name of certifier

Date (dd/mm/yyyy)

/ /

Please provide a copy of this certification.

Please outline your educational qualifications, degrees and certificates that you hold. Please include the year they were achieved.

Secondary school (i.e. year 10, year 12)

Year achieved (dd/mm/yyyy)

/ /

Tertiary (University, technical college)

Year achieved (dd/mm/yyyy)

/ /

TAFE

Year achieved (dd/mm/yyyy)

/ /

Other

Year achieved (dd/mm/yyyy)

/ /

5 Other benefits and entitlements

Have you claimed a permanent disability, terminal illness or similar benefit in the past?

◯ Yes ◯ No

If **yes**:

Insurance company or superannuation fund name

Was your claim accepted?

◯ Yes ◯ No

Claim or member number

Date claim submitted (dd/mm/yyyy)

/ /

Amount of benefit

$

Have you claimed, or do you plan to claim, other insurance for this or another illness or injury?

◯ Yes ◯ No

If **yes**:

Insurance company or superannuation fund name

Was your claim accepted?

◯ Yes ◯ No

Claim or member number

Date claim submitted (dd/mm/yyyy)

/ /

Amount of benefit

$

Have you claimed, or do you plan to claim, a benefit from WorkCover (workers' compensation)?

◯ Yes ◯ No

If **yes**:

Was your claim accepted?

◯ Yes ◯ No

Start date (dd/mm/yyyy)

/ /

End date (dd/mm/yyyy)

/ /

WorkCover claim number

Have you claimed, or do you plan to claim, Department of Human Services entitlements? (e.g. Centrelink, Department of Veterans' Affairs etc.)

◯ Yes ◯ No

If **yes**:

Start date (dd/mm/yyyy)

___ / ___ / ______

End date (dd/mm/yyyy)

___ / ___ / ______

Details

Other (please specify)

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

Start date (dd/mm/yyyy)

___ / ___ / ______

End date (dd/mm/yyyy)

___ / ___ / ______

Details (including details of any regular or lump sum payments you receive/d)

6 Activities

Please indicate your capacity to do the following activities:

Activities of daily living	Able	Unable
Dress yourself (e.g. putting on and taking off clothes)	◯	◯
Bathe yourself (e.g. washing and showering)	◯	◯
Toileting (e.g. using the toilet, including getting on and off)	◯	◯
Mobility (e.g. walking, getting in and out of a chair or bed)	◯	◯
Can you feed yourself? (e.g. getting food from a plate to your mouth)	◯	◯
Housework (e.g. cooking and cleaning)	◯	◯
Are you able to drive?	◯	◯

If you are unable to do any of the above, please provide additional comments on any capacity restrictions:

7 Financial representative

☐ I would like to give QSuper the authority to release information about my superannuation account/s to a financial representative (including financial adviser, solicitor, accountant, or tax adviser), and have attached a completed *Authority to Release Information to a Financial Representative* form available at **qsuper.qld.gov.au/forms**

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.

We, ***QInsure***, collect and use 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.

Even if we collect information from health providers (such as your General Practitioner), before the insurance starts you must still tell us every matter (including about your health) that is relevant to our decision about whether to offer you insurance, and if so, on what terms. This is your Duty of Disclosure under the *Insurance Contracts Act 1984* (Cth).

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 4 weeks; 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.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

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

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 ***QInsure***, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form ***QInsure*** 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.
- ***QInsure*** 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 ***QInsure*** 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 electronically or consented verbally.

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 ***QInsure***, or to third parties they engage, only if ***QInsure*** 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 four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- ***QInsure*** 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 ***QInsure*** 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 electronically or consented verbally.

Name

Signature

Date signed (dd/mm/yyyy)

/ /

Declaration and Authorisation

- I am the member named on this form or I have power of attorney to act on the member's behalf.
- I understand that my insurance will be cancelled if QSuper does not receive any money into my Accumulation account for 13 continuous months and I have not permanently opted in to cover.
- I confirm the information provided on this form is true and correct, and I have not withheld any information relevant to my claim.
- I agree to provide all medical information and undertake any medical examinations or occupational assessments requested by QSuper.
- I understand that a photocopy of my authority is considered as valid as the original.
- I understand ***QInsure*** will collect, use, and disclose my personal information consistent with these authorities.
- I authorise ***QInsure*** and its service providers, to collect my personal and medical information from the individuals and organisations listed below, for use in assessing and managing my claim:
  - Workers' compensation insurer
  - CTP insurer, other insurers, and other superannuation funds
  - Federal and State Government agencies including the Department of Human Services, the Department of Veterans' Affairs, and the Australian Taxation Office (ATO)
  - My employer
  - Rehabilitation, allied health, and return-to-work professionals appointed by me, my employer, other insurers, or my lawyer.
  - My accountant.
- I authorise ***QInsure*** to disclose my personal and medical information to the individuals and organisations below as part of managing my claim:
  - My employer
  - Rehabilitation, allied health, and return-to-work professionals appointed by me, other insurers, or my lawyer
  - Medical professionals for health, wellbeing, and rehabilitation, including my doctors, specialists, allied health providers, and their agents
  - Other service providers and advisers appointed by ***QInsure*** to carry out functions to assist in managing my claim
  - ***QInsure's*** appointed assessor, which may be located in or outside of Australia

Name

Signature

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, please return to us immediately by:

- Email: **insuranceclaims@qsuper.qld.gov.au**
- Post:
  QSuper
  Insurance Operations
  GPO Box 200
  Brisbane QLD 4001
- Fax: **07 3239 1139**
- In person at one of our Member Centres:
  70 Eagle Street Brisbane
  63 George Street Brisbane
  Sunshine Coast University Hospital, Ground Floor, Main Hospital Building, 6 Doherty Street, Birtinya

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

Member Centres
70 Eagle Street, Brisbane
63 George Street, Brisbane
Sunshine Coast University Hospital, Ground Floor, Main Hospital Building, 6 Doherty Street, Birtinya

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
Fax 1300 242 070
Website qsuper.qld.gov.au

This form and all products are issued by the QSuper Board (ABN 32 125 059 006, AFSL 489650) as trustee for QSuper (ABN 60 905 115 063). We take the privacy of your personal information very seriously. We are collecting your personal information to assess your claim for an insurance benefit and are authorised to do this under the *Superannuation (State Public Sector) Act 1990*. If we do not receive complete and accurate information, we may not be able to assess your claim. 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. We may disclose your information to other third parties (e.g. superannuation funds and government departments or agencies) with your consent or if we're authorised or required to by law. If you want to know more about our privacy policy, including how to access or correct your information, you can download QSuper's *Your Privacy factsheet* from our website or call us on 1300 360 750 and request a copy.

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Total and Permanent Disability (TPD) Benefit Claim

(Part B) – Employer's Statement

Your employee is making a claim for a total and permanent disability benefit through QSuper. This section of the claim form needs to be completed by your Human Resources (HR) or payroll office staff. Please ensure you have answered all questions before you send it to us.

1 Employee information

Title

First name

Last name

Date of birth (dd/mm/yyyy)

/ /

Payroll number

Position/job title

Place of employment and region

Are they still employed with the company?

◯ Yes ◯ No

If **no**, what date was their employment terminated? (dd/mm/yyyy)

/ /

What is the reason they were terminated?

Prior to going on leave, did your employee work in a reduced capacity?

◯ Yes ◯ No

If **yes**, please provide details:

2 Employment information

Please supply a position description for your employee's usual role.

Does your employee work:

◯ Full-time

◯ Part-time

Part-time fortnightly ratio

◯ Casual

◯ Contractor

Contract end date (dd/mm/yyyy)

/ /

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

/ /

What date did your employee commence with the company? (dd/mm/yyyy)

/ /

3 Additional comments

Please supply any information that clarifies or supports this Employer's 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)

/ /

Where to send the completed form

Once you have completed this form and attached any necessary documents, please return to us immediately by:

- Email: **insuranceclaims@qsuper.qld.gov.au**
- Post:

  QSuper
  Insurance Operations
  GPO Box 200
  Brisbane QLD 4001
- Fax: **07 3239 1139**

Additional information about this form

You will need to complete this Employer's Statement on request for any employee who is claiming a TPD benefit through QSuper.

Please ensure you complete all the sections in the Employer's Statement before returning to QSuper promptly. This will help us to progress the assessment of your employee's claim as quickly as possible.

If your employee's situation changes, it is important you let us know straight away. This includes changing the type of leave they take, if they start working again, or their employment is terminated. Please call us on **1300 360 750** or email us at **insuranceclaims@qsuper.qld.gov.au** to inform us of any changes.

Member Centres
70 Eagle Street, Brisbane
63 George Street, Brisbane
Sunshine Coast University Hospital, Ground Floor, Main Hospital Building, 6 Doherty Street, Birtinya

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
Fax 1300 242 070
Website qsuper.qld.gov.au

This form and all products are issued by the QSuper Board (ABN 32 125 059 006, AFSL 489650) as trustee for QSuper (ABN 60 905 115 063). We take the privacy of your employee's personal information very seriously. We have provided your employee with information about our privacy policy in their Member Statement. For more information about our privacy policy, you can download QSuper's privacy factsheet from our website or call us on 1300 360 750 to request a copy.

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Total and Permanent Disability (TPD) Benefit Claim

(Part C) – Doctor's Statement

Your patient is making a claim for a TPD benefit through QSuper. This section of the claim form needs to be completed by their treating doctor. QSuper will use this information as part of the assessment of your patient's eligibility for a permanent disability benefit.

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

If you have any questions when 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.

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

1 Patient information

Title

First name

Last name

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

  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)

  / /

- No

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

Name

Speciality (e.g. cardiovascular)

Practice name

Phone number

Email address

Postal address

State Postcode

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 the 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 symptoms relating to this condition.

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

/ /

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

Yes No

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

/ /

Please provide details:

Does the patient have an additional diagnosis?

Yes No

If **yes**, please describe:

Please describe your objective findings that support the diagnosis.

What are the additional symptoms?

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

/ /

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

Yes No

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

/ /

Please provide details:

4 Treatment information

What active treatment (e.g. physiotherapy, surgery, counselling or 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 attach further information outlining the details, including the 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:

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

Has the patient seen or 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)
/ /

5 Patient's functional capacity

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

Is the patient currently performing their usual work duties?

◯ Yes ◯ No

If **no**, please provide details:

If the patient has ceased all work, have they been certified in writing by you or another medical practitioner as unable to work due to the injury or illness?

◯ Yes ◯ No

If **yes**, what date was certification completed? (dd/mm/yyyy)

/ /

How do the symptoms affect the patient in their day to day activities?

How do the symptoms impact on the patient's functional ability to undertake work?

If the patient has ceased all work, do their symptoms present a barrier to their return to work?

◯ Yes ◯ No

If **yes**, please provide details:

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 – QSuper does not accept electronic signatures on this form)

Date signed (dd/mm/yyyy)

/ /

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Where to send the completed form

Once you have completed this form and attached any necessary documents, please return to us immediately by:

- Email: **insuranceclaims@qsuper.qld.gov.au**
- Post:

  QSuper
  Insurance Operations
  GPO Box 200
  Brisbane QLD 4001
- Fax: **07 3239 1139**

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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

Postal address

GPO Box 200, Brisbane QLD 4001

Fax

1300 241 602 (+617 3239 1111 if overseas)

Member Centres

70 Eagle Street, Brisbane

63 George Street, Brisbane

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

qsuper.qld.gov.au

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