THIS IS AN INTERACTIVE FORM

CFS Edge Super/Pension
Permanent incapacity application

SAVE FORM

PRINT FORM

This form can be used to apply for the early release of your superannuation on a permanent incapacity claim.

Mark appropriate answer boxes with a cross like the following [X]. Start at the left of each answer space and leave a gap between words. All fields marked with an asterisk (*) are mandatory and are required for us to complete your request.

If you have insurance on your CFS Edge Super account and you have Total and permanent disability (TPD) cover, please ensure you have first contacted the insurer to make a TPD claim before submitting this request.

Please upload the completed form to the Document Library via our online portal.
Telephone (for assistance) 1300 769 619

1 ACCOUNT DETAILS

*Account number

*Account name

2 TAX FILE NUMBER

You're not obliged to disclose your Tax File Number (TFN), but there may be tax consequences including additional tax on a permanent incapacity payment if it has not been provided. Refer to the Product Disclosure Statement (PDS) for information on the implications of not providing your TFN.

Tax File Number (if you have not previously provided it) ☐☐☐ ☐☐☐ ☐☐☐

We are authorised under the *Superannuation Industry (Supervision) Act (Cth)* to collect your TFN for this application. We may also use your TFN to administer other superannuation accounts or investment accounts you hold with us in the future. Where we use your TFN in this way, we will only use it for legal purposes, such as to calculate tax on your benefits, provide information to the Commissioner of Taxation or search for your other super accounts.

3 INTENTION TO CLAIM A TAX DEDUCTION ON ANY PERSONAL CONTRIBUTIONS – use this section if you have received member contributions into your Superannuation account in the current or previous financial year

Do you intend to claim a tax deduction on any personal contributions?

☐ No (continue to **Section 4**)

☐ Yes (complete the Notice of intent to claim a deduction via the CFS Edge online portal. Your adviser can assist with initiating this transaction).

Important note:

The trustee will send an acknowledgment notice to all members who have returned a Notice of intent to claim a deduction.

To claim a deduction for your personal superannuation contribution you must have given us a valid Notice of intent to claim a deduction, on or before the day you lodge your income tax return (or the end of the next income year, whichever occurs first), and the trustee must have given you an acknowledgment notice.

You cannot lodge or vary a notice of intent to claim a deduction if:

- the fund named on this form has commenced paying a pension based on part or all of the contributions for which you intend to claim a deduction; or
- you have previously withdrawn an amount or rolled out to another fund all or part of the contribution for which you want to claim a deduction.

4 LUMP SUM PAYMENT DETAILS

Note: Any changes to the bank account details must be initialled.

You can only nominate a bank account that is held in your name. This includes a joint account where you are one of the account holders.

*Branch number (BSB) ☐☐☐ — ☐☐☐

*Account number ☐☐☐☐☐☐☐☐☐

*Name of bank account

5 WITHDRAWAL AMOUNT

5.1 PARTIAL WITHDRAWAL DETAILS

☐ Partial lump sum for $

This withdrawal will be made gross of fees and taxes.

Please ensure there are sufficient funds in the cash account or that trades have been placed on your account to cover this request and minimum cash balance requirements. You are required to maintain a minimum of $10,000 in your account after any partial withdrawals. If required, we will adjust your payment amount to ensure this minimum is maintained.

OR

5.2 FULL CLOSURE WITHDRAWAL DETAILS

☐ Full lump sum and closure of the account

Does this account hold suspended funds, outstanding redemptions and/or corporate actions that may prevent this transaction being processed in one amount?

☐ No (continue to **Section 6**)

☐ Yes

☐ Transfer as much as possible now, and the remainder when it is available in the cash account

☐ Transfer the whole amount once it is available in the cash account

If no selection is made above we will transfer the **whole amount once it is all available in the cash account** unless there are suspended funds that are not immediately redeemable. In those cases we will transfer the available cash once all liquid funds have been redeemed.

Are you closing an Allocated Pension account which holds suspended funds?

☐ No (continue to **Section 6**)

☐ Yes

☐ Please ensure the current financial year minimum pension payment requirements have been met in full then cancel ongoing payments

☐ Please ensure there is sufficient cash available to continue making the regular pension payments for the remainder of the current financial year

If no selection is made, we will keep sufficient cash in the account to continue making the regular pension payments for the remainder of the current financial year.

Please note: If you have insurance on this account, your insurance cover will continue in accordance with the policy terms until your account is closed and insurance premiums will continue being deducted from your superannuation account.

Please contact your adviser to discuss your options if you require insurance cover once the superannuation account has been closed.

6 DECLARATION AND SIGNATURE

I declare that:

- all details in this form are true and correct,
- I am permanently incapacitated and, because I have remained permanently incapacitated, I have not engaged in gainful employment for which I am reasonably qualified by Education, Training or Experience (SIS Regulations 1994) to date,
- if this form is signed under Power of Attorney, the Attorney declares they have not received notice of revocation of that power, and
- I consent to my information being used in accordance with the CFS privacy policy.

*Member signature

*Name

*Date

dd/mm/yyyy

If you complete this declaration with a wet signature, please submit a copy of your certified ID to accompany this request.

7 PROVING YOUR IDENTITY

If you have not previously provided proof of your identity to us, please attach a certified copies of your original identification documents to this request. You will need to do so before we can pay you your benefit. Proving your identity ensures your benefit is paid to you and no one else. There may be times we need to contact you to further verify your identity.

Please attach the following proof of identity documents to this request:

☐ Certified copy of one of the following identification documents:

- Current Australian driver's licence
- Current Proof of Age card
- Current passport (Australian passports can have expired in the last 2 years)

OR

☐ One of the following documents:

- Birth certificate or birth extract
- Citizenship certificate issued by the Australian Government
- Pension card issued in your name by the Department of Human Services that entitles you to a financial benefit

AND one of the following which must contain your current name and address:

- Notice issued by the Department of Human Services that shows a financial benefit has been provided to you (issued within the last 12 months)
- ATO notice of assessment (issued within the last 12 months)
- Local council rates notice (issued within the last three months)
- Electricity or gas notice (issued within the last three months)

Please call us on 1300 769 619 if you are unable to provide the identification documentation listed above, and we can assist you with what can be provided based on your circumstances.

INSTRUCTIONS FOR CERTIFICATION

Who can certify documents?

In Australia, the following people can certify your documents:

- Architect, chiropractor, dentist, legal practitioner, medical practitioner, midwife, nurse, occupational therapist, optometrist, patent attorney, pharmacist, physiotherapist, psychologist, trademarks attorney, veterinary surgeon, Justice of the Peace, police officer, magistrate or judge, notary public
- Your financial adviser (provided they have two or more years of continuous service)
- Your accountant (provided they hold a current membership to a professional accounting body)
- An officer of a bank, building society, credit union or finance company provided they have two or more years of continuous service.
- Australian consular officer or an Australian diplomatic officer (within the meaning of the *Consular Fees Act 1955 (Cth)*)

What should your certified document/s look like?

After the certifier is satisfied the copy is a true copy, they will:

- Write or stamp 'True copy of the original document' on **every page**,
- Sign and date the document,
- Write their name and qualification,
- Apply a registration number (if applicable to their certifying authority, e.g. Justice of the Peace, reg #123456, CPA #123456), and/or company/employer name, and
- Apply a stamp (if applicable to their certifying authority).

CHECKLIST

Before you upload this form online, please use the following checklist to ensure that you've completed all of the necessary sections and all required information has been supplied.

Note: Failure to complete any of the required sections may delay the application being processed.

☐ This application has been completed in full (pages 1–2).

☐ I have provided payment instructions in **Section 4** as well as the amount I wish to withdraw in **Section 5** (note the amount you receive may be less than you request due to tax).

☐ I have included all of my certified identification in **Section 7**.

☐ I have included **two medical reports** in **Section 8**, completed by different medical practitioners.

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8 MEDICAL REPORTS

MEDICAL REPORT 1

Give this form to your medical practitioner to complete and return to you.

The Trustee of Avanteos Superannuation Trust requires the information requested in this Medical Report in order to make a decision on the members' superannuation benefit entitlement on grounds of permanent incapacity. It will not be used for any other purpose. Without it, the Trustee will not be able to reach a decision

Account and Member details

Account number

Account name

Member full name

Date of birth

dd/mm/yyyy

Member address

Unit number | Street number | PO Box | Street name

Suburb | State | Postcode

Country

Medical Practitioner details

Medical practitioner name

Practice name

Business address

Unit number | Street number | PO Box | Street name

Suburb | State | Postcode

Country

Contact number

Email address

Permanent incapacity details – medical practitioner to complete

1. Please describe the medical conditions (including references to relevant symptoms and restrictions) suffered by the member:

2. With reference to the comments provided at point 1. above, please describe the severity and the extent of the member's condition:

3. Please detail how the member's condition(s) affects their ability to continue (or return to) working in any capacity:

Permanent incapacity details – medical practitioner to complete (continued)

4. Please provide details of the current treatment and ongoing management the member is receiving for their condition(s):

5. In your opinion, do you believe that careful management of the member's condition might enable the member to return to some appropriate form of employment in the future?

Yes ☐ No ☐

If **YES**, please provide details of the management, approach to be applied and advise as to the forms of employments which might be relevant to the member in the future:

6. Are you able to form the opinion that because of his/her medical condition or mental ill-health, the member is unlikely to ever engage in gainful employment for which the member is reasonably qualified by education, training or experience?

Yes ☐ No ☐

If **NO**, please provide examples of the type of work, which you consider the member may be able to perform:

7. In your opinion, will the member ever be capable of returning to the workforce on a part-time or casual restricted basis:

Yes ☐ No ☐

If **YES**, please provide details of the type of work you believe the member maybe able to perform on a restricted or part-time basis. Also details of the restrictions, which may apply:

MEDICAL PRACTITIONER ACKNOWLEDGEMENT

This medical report has been completed based on my interactions, dealings and examination of the member. The information contained in the medical report is to the best of my knowledge, skills and expertise true and accurate as at the date of this report.

I understand that Avanteos Investments Limited, being the Trustee of the Fund may wish to confer with me in relation to any of the information provided, which requires further clarification.

I confirm that I am a Registered Medical Practitioner.

Full name

Qualification

Signature

Date

dd/mm/yyyy

MEDICAL REPORT 2

Give this form to your medical practitioner to complete and return to you.

The Trustee of Avanteos Superannuation Trust requires the information requested in this Medical Report in order to make a decision on the members' superannuation benefit entitlement on grounds of permanent incapacity. It will not be used for any other purpose. Without it, the Trustee will not be able to reach a decision

Account and Member details

Account number

Account name

Member full name

Date of birth dd/mm/yyyy

Member address

Unit number | Street number | PO Box | Street name

Suburb | State | Postcode

Country

Medical Practitioner details

Medical practitioner name

Practice name

Business address

Unit number | Street number | PO Box | Street name

Suburb | State | Postcode

Country

Contact number

Email address

Permanent incapacity details – medical practitioner to complete

1. Please describe the medical conditions (including references to relevant symptoms and restrictions) suffered by the member:

2. With reference to the comments provided at point 1. above, please describe the severity and the extent of the member's condition:

3. Please detail how the member's condition(s) affects their ability to continue (or return to) working in any capacity:

Permanent incapacity details – medical practitioner to complete (continued)

4. Please provide details of the current treatment and ongoing management the member is receiving for their condition(s):

5. In your opinion, do you believe that careful management of the member's condition might enable the member to return to some appropriate form of employment in the future?

Yes ☐ No ☐

If **YES**, please provide details of the management, approach to be applied and advise as to the forms of employments which might be relevant to the member in the future:

6. Are you able to form the opinion that because of his/her medical condition or mental ill-health, the member is unlikely to ever engage in gainful employment for which he/she is reasonably qualified by education, training or experience?

Yes ☐ No ☐

If **NO**, please provide examples of the type of work, which you consider the member may be able to perform:

7. In your opinion, will the member ever be capable of returning to the workforce on a part-time or casual restricted basis:

Yes ☐ No ☐

If **YES**, please provide details of the type of work you believe the member maybe able to perform on a restricted or part-time basis. Also details of the restrictions, which may apply:

MEDICAL PRACTITIONER ACKNOWLEDGEMENT

This medical report has been completed based on my interactions, dealings and examination of the member. The information contained in the medical report is to the best of my knowledge, skills and expertise true and accurate as at the date of this report.

I understand that Avanteos Investments Limited, being the Trustee of the Fund may wish to confer with me in relation to any of the information provided, which requires further clarification.

I confirm that I am a Registered Medical Practitioner.

Full name

Qualification

Signature

Date

dd/mm/yyyy