THIS IS AN INTERACTIVE FORM

CFS Edge Super/Pension Terminal medical condition application

SAVE FORM

PRINT FORM

This form can be used to grant you an early release of your super benefit on grounds of terminal medical condition. Once approved, you can use the *CFS Edge Super/Pension Withdrawal form* to withdraw cash from your account. Alternatively this form can be used to support a new CFS Edge Pension application under this condition of release.

Give this form to your treating specialist/medical practioner to complete and return to you. **Start at the left of each answer space and leave a gap between words. All fields are required to complete your request.**

Please upload the completed form to the Document Library via our online portal.

Telephone (for assistance) 1300 769 619

SECTION 1 ACCOUNT DETAILS

Account number

Account name

Member full name

Date of birth dd/mm/yyyy

SECTION 2 DECLARATION BY TREATING SPECIALIST/MEDICAL PRACTITIONER

DECLARATION 1

I, Dr

have been responsible for the treatment and care of

Full name of patient

of

Address of patient

since dd/mm/yyyy.

It is my opinion that this patient is suffering from a medical condition[1]/has incurred an injury[1] that is likely to result in his/her death within a period that ends not more than 24 months after the date of this certification (the certification period).

Signature of physician

Name of physician

Date dd/mm/yyyy

If specialist, please state field of practice

Address of physician

Qualifications

Contact number

Email address

For a superannuation fund member to be able to access superannuation benefit on the ground of terminal medical condition, **two medical practitioners, at least one of whom is a specialist practising in the area related to the illness or injury suffered by the person,** must provide a certification and, for each of the certificates the certification period must not have ended.

Note: any charge/fee by the member's treating specialist and medical practitioner for this certification must be paid by the member.

1 Delete or strike-through as applicable.

DECLARATION 2

I, Dr

have been responsible for the treatment and care of

Full name of patient

of since dd/mm/yyyy.

Address of patient

It is my opinion that this patient is suffering from a medical condition[1]/has incurred an injury[1] that is likely to result in his/her death within a period that ends not more than 24 months after the date of this certification (the certification period).

Signature of physician

Name of physician

Date dd/mm/yyyy

If specialist, please state field of practice

Address of physician

Qualifications

Contact number

Email address

For a superannuation fund member to be able to access superannuation benefit on the ground of terminal medical condition, **two medical practitioners, at least one of whom is a specialist practising in the area related to the illness or injury suffered by the person,** must provide a certification and, for each of the certificates the certification period must not have ended.

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