

CERTIFICATE OF PERMANENT INCAPACITY

Member Name: _____

Member Number: _____

Occupation: _____

Qualification: _____

Date of Birth: _____ / _____ / _____

This certificate will assist the Trustee to determine whether the member is eligible for release of their preserved superannuation benefit under the definition of permanent incapacity as specified in *Regulation 1.03C Superannuation Industry (Supervision) Regulation*.

Declaration by Medical Practitioner

Name of Medical Practitioner: _____

(Please print clearly)

Qualifications: _____

Address: _____

Daytime contact phone no: (____) _____

I understand that _____ has ceased to be gainfully employed and is claiming payment of a benefit from the Praemium SMA Superannuation Fund on the grounds of permanent incapacity.

I certify that:

- The abovenamed member is suffering from a medical condition (whether physical or mental) which, in my opinion, makes it unlikely that they will ever be able to engage in gainful employment for which they are reasonably qualified by education, training or experience.
- Their incapacity is caused by *(please print clearly)*: _____
- In my opinion, the member has suffered from this condition for _____ years and _____ months.

Signature: _____

Date: _____ / _____ / _____