APPLICATION FOR INVALIDITY BENEFIT – EMPLOYER STATEMENT

ACTIVE SUPER

This form is to be completed by your employer. The following information is required to assess your eligibility for an invalidity benefit.

You can complete this form by typing directly onto it, or by using a black pen and capital letters. Use a (✓) to mark boxes.

Please select which scheme(s) you are a member of and enter your member number(s):

◯ **Retirement Scheme**

Member no.

◯ **Defined Benefit Scheme**

Member no.

1. MEMBER INFORMATION

Full member name

Date of birth (DD MM YY)

Date employment terminated

Reason for termination

☐ Resignation ☐ Medical termination

☐ Aged retirement ☐ Other (please specify)

Member's termination notice/letter is attached ☐ Yes ☐ No

Employment status prior to termination

Please tick ONLY ONE (1) of these options

☐ Permanent full-time ☐ Permanent part-time ☐ Casual

Full-time annual salary at Scheme exit date $

If employee was part-time, please provide attributed full-time salary $

Last date actively employed (DD MM YY)

Commencement date of current position (DD MM YY)

a. Occupation or classification

b. Major duties

c. Job description attached ☐ Yes ☐ No

d. Was the member fully engaged in those duties prior to termination? ☐ Yes ☐ No

e. If 'No', what alternate duties were being performed?

f. How long were these alternate duties performed prior to termination?

g. Would the member be able to perform these or like duties on a permanent basis? ☐ Yes ☐ No

h. How many days of sick leave were taken in the last 12 months of employment?

i. Have Workers' Compensation payments been made? ☐ Yes ☐ No

j. If 'Yes', please provide details, and attach copies of relevant information.

IMPORTANT

Where a member is under maturity age* and is approved for a pension on the grounds of invalidity, if their health is restored to a level that enables them to return to pre-retirement employment the trustee may communicate with the Employer in this regard in accordance with the rules of the Scheme.

Maturity age is 60 years of age except in the case of a female member of the Defined Benefit Scheme who elected to contribute at the rate prescribed for retirement at age 55.

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1. MEMBER INFORMATION (CONT.)

k. Has any rehabilitation attempt been made? ☐ Yes ☐ No

l. If 'Yes', please provide details, and attach copies of relevant information

m. Are there any other alternate roles that the employee would be able to perform if unable to return to their normal occupation? ☐ Yes ☐ No

n. If 'Yes', please provide details.

o. Are you aware of the employee being engaged in any other form of employment since ceasing employment with you? ☐ Yes ☐ No

p. If 'Yes', please provide details.

q. Are you aware of any other factors that may assist us or has any relevance to this application? ☐ Yes ☐ No

r. If 'Yes', please provide details.

2. INVALIDITY BENEFIT STATUTORY DECLARATION

Please ONLY complete this section if the former employee was medically terminated or medically dismissed.

I MAKE this solemn declaration conscientiously believing the same to be true, and by virtue of the provisions of the *Oaths Act 1900* (NSW).

Declared at (Suburb/City/Town) _____ **in the State of New South Wales**

Signed (employer) _____ **on** (DD MM YY) ☐☐☐☐☐☐

in the presence of an authorised witness, who states:

I, (name of authorised witness) _____

(qualification of authorised witness) _____

certify the following matters concerning the making of this statutory declaration by the person who made it:

Please use a (✓) to mark the box that applies in both 1 and 2.

1.

☐ I saw the face of the person.

OR

☐ I did not see the face of the person because the person was wearing a face covering, but I am satisfied that the person had a special justification for not removing the covering.

2.

☐ I have known the person for at least 12 months.

OR

☐ I have not known the person for at least 12 months but I have confirmed the person's identity using an identification document and the document I relied on was a

_____

(describe identification document relied on)

AUTHORISED WITNESSES

- **a solicitor or barrister who has a current practising certificate (whether NSW or some other State/Territory);**
- **a Justice of the Peace;**
- **a notary public;**
- **a commissioner of the court for taking affidavits; a person by law who may administer an oath.**

3. I also certify that the requirements of the *Oaths Act 1900* (NSW) have been complied with.

Signed _____ **on** (DD MM YY) ☐☐☐☐☐☐

3. EMPLOYER DETAILS AND DECLARATION

Employer name

Phone no.

I declare that I have fully read this form and the information completed is true and correct.

I certify that I have obtained the necessary consent to disclose personal information to Active Super.

Name of authorised person

Position

Signed

Date (DD MM YY)

SEND YOUR COMPLETED FORM BACK TO US AT:

Mail Active Super, PO Box N835, Grosvenor Place NSW 1220

Email admin@activesuper.com.au

Privacy Collection Statement

The information provided on this form is collected by LGSS Pty Limited (ABN 68 078 003 497) as Trustee for Local Government Super (ABN 28 901 371 321) ('Active Super') for the purposes of administering accounts and providing services to you associated with fund membership. If you do not provide the requested information, Active Super may not be able to perform these services. Your personal information may be shared with our administrator, other superannuation trustees and other service providers, in order to be able to provide our services to you. We may provide information to government, regulatory or other bodies if required by law. For further information about how we manage and protect personal information, please refer to our privacy policy available at activesuper.com.au/privacy-policy or by calling us on 1300 547 873. It sets out how we use the information we hold about you, how you can access and correct the information, how you may complain about a breach of privacy and our process for resolving privacy related enquiries and complaints.

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