

Dear member

Your request for early release of your super benefits (terminal illness)

For us to assess your request, you need to provide us with two certificates (one signed by a registered medical practitioner and one signed by a registered medical practitioner/ specialist who is practicing in an area related to the illness or injury), certifying that, in their opinion, you suffer from an illness, or have incurred an injury, that is likely to result in your death within 12 months of the date of certification. I have attached two statements in the required format for your convenience.

When we receive the above documentation, we will promptly assess your request and we will advise you of our decision accordingly.

Please note that we may require confirmation of the information you provide to us.

If you require any further information, please contact your financial planner or our Client Advisory Services on 1800 221 151.

Yours faithfully



Sam Alexiou
Client Advisory Services Manager

Retirement Fund

Terminal illness statement by a registered medical practitioner

1. Client details

Title	Surname	Given names
<input type="text"/>	<input type="text"/>	<input type="text"/>

Residential address

Suburb/town	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>

Telephone (home)	Telephone (business)	Mobile
<input type="text"/>	<input type="text"/>	<input type="text"/>

Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of birth (dd/mm/yy) <input type="text"/> / <input type="text"/> / <input type="text"/>	Email address <input type="text"/>
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TFN
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I understand that the above client is a member of The Portfolio Service Retirement Fund and has made a claim for payment of benefits on the grounds of terminal illness. The member's terminal illness: (Please print)

I certify that, in my opinion, the member suffers from an illness, or has incurred an injury, that is likely to result in their death within 12 months of the date of certification.

Signature <input type="text"/>	Date <input type="text"/> / <input type="text"/> / <input type="text"/>
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Address

Telephone

Practice/hospital stamp

OR
Attach business card to the form here

Retirement Fund

Terminal illness statement by a registered medical practitioner/specialist

1. Client details

Title	Surname	Given names
<input type="text"/>	<input type="text"/>	<input type="text"/>

Address

Suburb/town	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>

Telephone (home)	Telephone (business)	Mobile
<input type="text"/>	<input type="text"/>	<input type="text"/>

Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of birth (dd/mm/yy) <input type="text"/> / <input type="text"/> / <input type="text"/>	Email address <input type="text"/>
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TFN
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I understand that the above client is a member of The Portfolio Service Retirement Fund and has made a claim for payment of benefits on the grounds of terminal illness. The member's terminal illness: (Please print)

I certify that, in my opinion, the member suffers from an illness, or has incurred an injury, that is likely to result in their death within 12 months of the date of certification.

Signature	Date
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Address

Telephone

Practice/hospital stamp

OR
Attach business card to the form here