LIFE INSURANCE

Withdrawal of the superannuation benefits on grounds of Total and Permanent Disablement

Policy number

Case number

This form is forwarded to you after your request to withdraw. Please complete it, have your Doctor complete the certificate overleaf and return them both to us as soon as possible. This form's issue is in no way an admission of liability. If you have insurance covering disablement, do not use this form.

Section 1: Member details

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name

Middle name

Last name

Date of birth (DD/MM/YYYY)

Email

Home telephone

Business telephone

Mobile

Residential address

Unit number

Street number

Street name

Suburb

State

Postcode

Country

The Trustee
NULIS Nominees (Australia) Limited
ABN 80 008 515 633 AFSL 236465

The Fund
MLC Super Fund
ABN 70 732 426 024

The Insurer
Insurance is issued by MLC Limited
ABN 90 000 000 402 AFSL 230694

Section 2: Occupation details

Usual or previous occupation (if more than one, state all)

Name of last employer

Address of last employer

Unit number | Street number | PO Box | Street name

Suburb | State | Postcode | Country

On what date did you last work?

Section 3: Disability details

1. **Describe the complaint/health condition that you are claiming benefits for.**

2. **How long have you suffered from this condition?**

3. **Names of the two registered medical practitioners consulted (block letters)**

Section 4: Declaration

I declare that the above particulars are correct.

Name of Member

Name of Witness

Signature of Member

X Date (DD/MM/YY)

Signature of Witness

X Date (DD/MM/YY)

If you have any questions you can call us on **1300 125 246**, 8.30am to 6pm AEST, Monday to Friday.

OCM1285-0821
A124687

LIFE INSURANCE

Certificate of Treating Doctor

Section 1: Patient details

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name

Middle name

Last name

Date of birth (DD/MM/YYYY)

Email

Home telephone

Business telephone

Mobile

Section 2: Medical details

1. How long have you known the patient?

2. What is the diagnosis?

Where applicable indicate the severity of condition (eg mild, moderate, severe).

3. How long has the patient suffered this condition?

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Section 2: Medical details continued

4. **Do you consider the patient totally and continuously incapable of working in their usual occupation?**

No ☐

Yes ☐ From what date? | | | | | | |

5. **In your opinion is the patient likely to ever be able to work again in any gainful employment for which they are reasonably qualified by education, training or experience?**

It is unlikely ☐

It is likely ☐ From what date? | | | | | | |

6. **If the patient is fit to work part-time, how many hours per week are they capable of working?**

hr/pw

Section 3: Prognosis

Section 4: Doctor's details

Note: Any charge for this certificate must be paid for by the patient.

Doctor's name (block letters)

Qualifications

Unit number | | | | |

Street number | | | | |

PO Box | | | | |

Street name

Suburb

State | | |

Postcode | | | | |

Country

Doctor's Signature

X

Date (DD/MM/YY) | | | | | | |

Section 5: Send us your form

Please return your completed, signed and dated form to:

MLC Life Insurance – Claims Support Team
PO Box 23314
Docklands VIC 3008

Email: claims.retail@mlcinsurance.com.au

If you have any questions you can call us on **1300 125 246**, 8.30am to 6pm AEST, Monday to Friday.

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