



Application for issue of invalidity retirement certificate

All sections to be completed by Employer

SECTION A Member's details

| | |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Reference number (AGS) | <input type="text"/> |
| Salutation | <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Other <input type="text"/> |
| Surname | <input type="text"/> |
| Given name(s) | <input type="text"/> |
| Date of birth | <input type="text"/> ^D <input type="text"/> ^D / <input type="text"/> ^M <input type="text"/> ^M / <input type="text"/> ^Y <input type="text"/> ^Y <input type="text"/> ^Y <input type="text"/> |
| Position title (in full) | <input type="text"/> |
| Address | RESIDENTIAL ADDRESS <input type="text"/> |
| | <input type="text"/> |
| | SUBURB <input type="text"/> STATE <input type="text"/> POST CODE <input type="text"/> |
| | POSTAL ADDRESS <input type="text"/> |
| | <input type="text"/> |
| | SUBURB <input type="text"/> STATE <input type="text"/> POST CODE <input type="text"/> |
| Phone | BUSINESS HOURS <input type="text"/> |
| | AFTER HOURS <input type="text"/> |
| | MOBILE NUMBER <input type="text"/> |
| Email address | <input type="text"/> |
| | @ <input type="text"/> |

SECTION B Employer's details

| | |
|----------------------------|---------------------------------------------------------------------------------------|
| Employer's name | <input type="text"/> |
| Employer's address | <input type="text"/> |
| | <input type="text"/> |
| | SUBURB <input type="text"/> STATE <input type="text"/> POST CODE <input type="text"/> |
| Case manager surname | <input type="text"/> |
| Case manager given name(s) | <input type="text"/> |
| | <input type="text"/> |
| Email address | <input type="text"/> |
| | @ <input type="text"/> |
| Payroll officer | <input type="text"/> |
| Phone number | BUSINESS HOURS <input type="text"/> |
| | <input type="text"/> |
| Email address | <input type="text"/> |
| | @ <input type="text"/> |

SECTION C Employment and superannuation details

Applicant is a member of *CSS Superannuation Act 1990*

| | | | | | | | | | |
|------------------------------------------------------------------------------------|------------------------------|-----------------------------|----------------------|---|----------------------|----------------------|----------------------|----------------------|----------------------|
| Date on which continuous sick/compensation leave commenced. | <input type="text"/> | / | <input type="text"/> | / | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date on which sick leave payments ceased/will cease. | <input type="text"/> | / | <input type="text"/> | / | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Member is in receipt of compensation benefits in respect of the current condition? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | | |
| Member has applied for compensation benefits? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | | |
| Date on which compensation payments ceased/will cease. | <input type="text"/> | / | <input type="text"/> | / | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Eligibility for preassessment payments will be determined routinely on receipt of complete application for IRC.

IMPORTANT: Member MUST be advised that pre-assessment payments will be recovered if compensation payments are granted.

SECTION D Checklist of attachments to this form SPC

- | | |
|-------------------------------------------------------------------------|------------------------------------------------------------------------------|
| <input type="checkbox"/> Sick leave records | <input type="checkbox"/> Independent specialists' reports |
| <input type="checkbox"/> Duty statement | <input type="checkbox"/> AMP reports |
| <input type="checkbox"/> Rehabilitation reports | <input type="checkbox"/> Form SM2 |
| <input type="checkbox"/> Treating doctors' reports | <input type="checkbox"/> Comcare recommendation (for all compensation cases) |
| <input type="checkbox"/> CMAPS (less than 3 years contributory service) | |

IMPORTANT: Member MUST be provided with information about invalidity retirement. Information leaflets are available from the Scheme website at www.css.gov.au

SECTION E Declaration by case manager

I certify that the above information is correct and that the member:

- has been provided with information about invalidity retirement and
- has been advised that pre-assessment payments will be recovered if compensation payments are granted.

Signature and date

| |
|-----------|
| SIGNATURE |
| |

Date signed

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| D | D | / | M | M | / | Y | Y | Y | Y |
| | | | | | | | | | |

END FORM