



# Total and Permanent Disability (TPD)

## What is a TPD Benefit?

A TPD Benefit is a sum of money paid in situations where an Energy Industries Accumulation or Executive Scheme member has to leave the workforce early because of an injury or medical condition that prevents them from working.

## How do I know if I may be able to claim a TPD Benefit?

To be able to claim a TPD Benefit you must have a physical or mental invalidity and you must not have deliberately contributed to creating that invalidity. Where you have basic insurance cover you also need to be assessed by the Insurer as being totally and permanently incapacitated (see the Definitions of TPD section in this fact sheet).

## What is in the Basic TPD Benefit?

The Basic TPD Benefit payment includes:

- Your personal superannuation account balance; and
- The amount of insurance cover designated for your age (where applicable).

## Can I choose how to receive the benefit payment?

You can choose from one of these options:

- Receive all or part of your benefit as cash (subject to superannuation preservation rules)
- Rollover all or part of your benefit to the Local Government Account-Based Pension or Rollover Plan or
- Rollover all or part of your benefit to another complying superannuation or rollover fund.

## What would disallow my claim for a TPD Benefit?

Claims that have been disallowed often contain difficult medical information that may be interpreted in different ways.

If your doctor's medical report does not conclusively show you are incapable of working again, the Insurer may request that you attend another specialist (at their cost).

If there is any evidence that you have undertaken employment since leaving your employer, this may disqualify you from receiving the benefit.

## Where do I get the claim forms?

The forms are available from your Scheme by calling Member Services on 1300 369 901. We can minimise the time taken to process your claim if you ensure that all forms are fully completed.

As you can see from the section 'How do I apply?' you will need to ask your treating doctor, and one other doctor, to complete reports for you. If you have any other medical reports (e.g. for Workers' Compensation purposes), please send us copies as well.

Don't forget to have the copy of your 'Proof of Age' certified by an authorised person as indicated on the form, including a solicitor or Justice of the Peace (JP).

## How do I apply?

For a fast turnaround, please complete each of the forms listed as follows (A to E) accurately. Make sure you, your employer and your doctors fill in each of the relevant sections.

Any additional relevant medical information may help your claim.



## Your checklist of what's needed

- A** Member Details & Payment Instructions.
- B** Employer's Statement.
- C** Attending Doctor's Statement, completed by your treating doctor.
- D** Incapacity Certificate, completed by a second doctor who you have consulted regarding your medical condition.
- E** Member Statement.

To further support your claim, please also supply a report from your specialist doctor (if available).

Unless you have already done so, please provide proof of age i.e. a certified copy of documents as indicated on the form. These may include:

- Birth certificate;
- Current passport or certificate of citizenship; or
- Current driver's licence.

If you have not already done so, you should also provide your Tax File Number so that the correct rate of tax can be applied to the payment.

## Rights of Appeal

If your application is declined or you are unhappy with the outcome, you can lodge an appeal by writing to:

### The Complaints Resolution Officer

PO Box N835  
Grosvenor Place NSW 1220

Remember to enclose any additional medical or other information you wish to be considered.

If you are not satisfied with the response from the Complaints Officer, you have the option of referring your claim to the Superannuation Complaints Tribunal.

Their contact details are:

### The Secretary

Superannuation Complaints Tribunal  
Locked Bag 3060 GPO  
Melbourne VIC 3001

Ph: **1300 780 808**

Summary of claim process - from date of lodgement	
Events	Total and Permanent Disability
A straightforward claim can often be paid within six weeks <sup>1</sup> , if all supporting documentation is completed, and provided that:	<ul style="list-style-type: none"> <li>■ You meet one of the Insurer's definitions of TPD</li> <li>■ You are permanently unable to undertake any future employment, taking into account your:               <ul style="list-style-type: none"> <li>■ Medical condition</li> <li>■ Age and educational level</li> <li>■ Skills and training and</li> <li>■ Where you live.</li> </ul> </li> </ul>
If there is insufficient medical evidence to make a decision immediately, we will ask you for more information. Assessment may take approximately four months <sup>1</sup> .	<p>You will be asked for more information on:</p> <ul style="list-style-type: none"> <li>■ Your disability, personal and work history and</li> <li>■ Any additional medical reports you have in your possession (including reports from specialists).</li> </ul> <p>You may also be asked to see a doctor as well as an Occupational Therapist nominated by the Insurer.</p>
If the evidence still does not support your claim, we will send you a "Show Cause" letter before any final determination is made.	<ul style="list-style-type: none"> <li>■ You will be advised that the Insurer is unlikely to approve payment and the reasons.</li> <li>■ You will have another 28 days to provide further information not previously provided.</li> </ul>
A committee composed of Trustees from your Scheme will consider your claim.	<ul style="list-style-type: none"> <li>■ Your case will then be reviewed, taking into consideration any additional information provided.</li> <li>■ The committee will notify you of its decision. See Rights of Appeal section for further information.</li> </ul>

<sup>1</sup> Please note, that due to the complexities involved, and the need to rely on medical assessments and written submissions, the entire process could take over 6 months.



## How do I qualify for a TPD Benefit?

If you obtain two written medical reports confirming that you are no longer able to work, you may qualify for payment of both your superannuation account balance and any additional insurance benefits you might have in the Scheme.

There is no self-assessment test allowing members to judge for themselves whether or not they fit the above description and how long it will take for a decision on their claim to be made. Some claims are straightforward, others less so (the summary of the claims process on the previous page may be of help).

In order to qualify for a TPD Benefit you need to be assessed by the Insurer to see whether you meet the definition of TPD as outlined in the Definition of TPD section below.

## Definitions of TPD

Depending on your class of membership, not all definitions of TPD will be applicable. The definitions for TPD are:

(a) Solely because of illness or injury you have suffered the permanent loss of:

- the use of two limbs (where 'limb' is defined as the whole hand below the wrist or the whole foot below the ankle)
- the sight in both eyes or
- the use of one limb and the sight in one eye

or

(b) Solely because of illness or injury:

- has suffered at least 25% whole person impairment (based on the latest edition of the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment', or an equivalent guide approved by us)
- is not engaged in any occupation and
- is disabled to such an extent as to render them unlikely to ever be engaged in any occupation for which they are reasonably suited by education, training or experience or

(c) Solely because of illness or injury is unlikely ever to be able to perform at least two of the following activities of daily living without assistance from another person:

- Dressing - put on and take off clothing
- Bathing - wash or shower
- Toileting - use of a toilet, including getting on and off
- Mobility - get in and out of bed and a chair
- Feeding - to get food from a plate into the mouth

or

(d) Where at the time of disablement, the insured person was employed 15 hours or more per week\* (averaged over the 13 week period prior to the date of disablement or such shorter period if employed for less than 13 weeks immediately prior to the date of disablement) and aged 65 or less;

- has been absent as a result of an illness or injury from employment for 6 consecutive months and
- after consideration of all relevant evidence, the Insurer assesses that the insured person is disabled to such an extent as to render them unlikely to ever again be engaged in any occupation for which they are reasonably suited by their education, training or experience or

(e) Where at the time of disablement, the insured person was not employed and was engaged in unpaid domestic duties at home:

- is, as a result of illness or injury, under the care of a Medical Practitioner
- is unable to perform those domestic duties
- is unable to leave their home unaided
- has not engaged in any gainful employment for a period of 6 consecutive months after the occurrence of the illness or injury and
- at the end of the period of 6 months, in the Insurer's opinion, after consideration of all relevant evidence the Insured Person is disabled to such an extent as to render them unlikely to perform those domestic duties or engage in any gainful occupation.

\* The requirement to work 15 or more hours per week is waived for the following categories of insured persons;  
 ■ casual employees of a participating employer who had cover in force prior to 1 August 2009;  
 ■ full time and permanent part time employees of a participating employer.



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## Fact sheet



### What if I have voluntary insurance?

You still need to submit your claim to us using the standard forms. We will then request additional information from you that will be provided to our Insurer. Our Insurer will assess your claim and may need to contact you if more information is required.

Refer to your latest benefit statement for details on your balance and insurance cover. Your Scheme's PDS describes how your insurance cover is calculated.

### Who can help me?

Before you make a decision, you should seek advice on your benefit, and how it will be taxed. You may also want help on how to set up a pension or with managing your retirement plan. If you do, call us and we can arrange for one of our financial planners to speak with you.

You can contact Member Services on 1300 369 901 for information about our financial planning service, how to make your claim and to follow its progress.

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Members should not rely solely on this information and should consider their own personal objectives, financial situation and needs before acting on this information. Prior to making any investment decision you should obtain and consider the relevant Product Disclosure Statement (PDS) pertaining to your Scheme membership and seek professional investment advice. Date issued: 31 March 2010

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**Energy Industries Superannuation Scheme Pty Ltd** (ABN 72 077 947 285) (ABN Pool A - 22 277 243 559 and ABN Pool B - 64 322 090 181)

**Sydney Office:** Ground Floor, 28 Margaret Street Sydney **Postal Address** PO Box N835, Grosvenor Place NSW 1220

**Tel:** 1300 369 901 **Fax:** (02) 9279 4131 **Website:** [www.eisuper.com.au](http://www.eisuper.com.au)