

# LINDFIELD SUPERANNUATION FUND

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Trustee:  
Diversa Trustees Limited  
ABN: 49 006 421 638  
AFSL: 235153  
Trustee No.: L0000635

## EARLY RELEASE OF SUPER DUE TO PERMANENT INCAPACITY— part I

This is the form you should fill out to apply for a withdrawal from your Lindfield Super account due to permanent incapacity.

Fund:  
ABN: 32 367 272 075  
USI: 32 367 272 075 156  
Fund Registration No.: R1001204

Post the completed form to GPO Box 263, Sydney, NSW 2001

### Section 1 Personal Details

Title and Given Name (s)

Surname

Date of Birth  Phone number

Email address  Gender

Residential address

City  State  Postcode

Member Number

### Section 2 Diagnosis

Please list all medical conditions (illness, injury or disability) which impact on your capacity to work:

Note – this form must be accompanied by:

- Part II: Statutory Declaration, with signature and details of the authorised witness. If the witness to your signature on the form is not an authorised witness the form cannot be considered as being legally valid and your request for early release of Superannuation Benefits will not be processed.
- Certificate by a registered Medical Specialist
- Certificate by a registered Medical Practitioner
- Completed Lindfield Super withdrawal form

**LINDFIELD SUPERANNUATION FUND**

This certificate is to be completed by a registered medical specialist.

Member Name

Member Number

I, the undersigned, understand that the abovementioned, being a member of the Lindfield Super, has ceased to be gainfully employed and has made claim on the Fund for payment of his / her benefit on the grounds of permanent incapacity.

The members permanent incapacity has been caused by:


In accordance with the Superannuation Industry (Supervision) Act 1993 and Regulations (Regulation 6 01 (2) and the Income Tax Assessment Act 1936 (Section 27G) covering payment of benefits due to permanent incapacity, I certify that in my opinion, the abovementioned member is unlikely ever again to engage in gainful employment for which he / she is reasonably qualified by education, training or experience.

Name

Qualifications

Address

Phone

.....  
Signature of Qualified person

...../...../.....  
Date

# LINDFIELD SUPERANNUATION FUND

This certificate is to be completed by a registered medical practitioner.

Member Name

Member Number

I, the undersigned, understand that the abovementioned, being a member of the Lindfield Super fund, has ceased to be gainfully employed and has made claim on the Fund for payment of his / her benefit on the grounds of permanent incapacity.

The members permanent incapacity has been caused by:


In accordance with the Superannuation Industry (Supervision) Act 1993 and Regulations (Regulation 6 01 (2) and the Income Tax Assessment Act 1936 (Section 27G) covering payment of benefits due to permanent incapacity, I certify that in my opinion, the abovementioned member is unlikely ever again to engage in gainful employment for which he / she is reasonably qualified by education, training or experience.

Name

Qualifications

Address

Phone

.....  
Signature of Qualified person

...../...../.....  
Date

EARLY RELEASE OF BENEFIT DUE TO PERMANENT INCAPACITY FORM – PART II

STATUTORY DECLARATION

I (insert name)....., (insert address).....

(insert occupation)..... do solemnly and sincerely declare that the information provided by me in the 'Early Release of benefit due to Permanent Incapacity Form – Part I' annexed to this Statutory Declaration is true and correct.

I also declare that I am unable to engage in gainful employment for which I am reasonably qualified by education, training or experience.

I make this solemn declaration by virtue of the Statutory Declaration Act 1959 as amended and subject to the penalties<sup>i</sup> provided in that Act for the making of false statements in the statutory declarations, conscientiously believing the statements contained in the declaration to be true in every particular.

Signed .....

(Signature of person making the declaration) - (Please sign in front of an authorised witness)

Declared at .....

(Location)

On .....

(Date)

Authorised witness before me .....

(Name of authorised witness – please print. Note the authorised witness must be either a: Justice of The Peace, Doctor, pharmacist or Australia Post Officer)

X.....

(Signature of person before whom the Declaration is made)

X.....

(Insert qualifications and address of person before whom the declaration is made)

<sup>i</sup> - A person who wilfully makes a false statement in a Statutory declaration under the Statutory Declaration Act 1959 as amended is guilty of an offence against this Act the punishment for which is a fine not exceeding \$200 or imprisonment for a term not exceeding 6 months or both if the offence is prosecuted summarily, or imprisonment for a term not exceeding four years if the offence is prosecuted upon indictment.