

# Certificate for release of benefit



Please complete in pen using CAPITAL letters and print (X) to mark boxes. Forms must be completed in full. Read the Privacy Collection Statement on this form to see how AustralianSuper uses your personal information.

## 1 To be completed by the AustralianSuper member

Last name															Mr	Mrs	Ms	Miss	Dr
B O T T E R I L L															<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First name/s																			
B R Y A N																			
Street address																			
6 / 7 W A S T E L L S T R E E T																			
Suburb/Town										State		Postcode							
N O R T H C O T E										V I C		3 0 7 0							
Date of birth					Member Number					Male		Female							
2 3 1 2 1 9 8 8					1 0 7 4 4 3 7 3 2 7					<input checked="" type="checkbox"/>		<input type="checkbox"/>							


## 2 To be completed by the doctor

1. I, the undersigned, understand that the above named being a member of AustralianSuper, has ceased to be gainfully employed and has made a claim on the Fund for payment of his/her benefit on the grounds of permanent incapacity. The member's incapacity has been caused by:

Patient has had ongoing issues with cognitive dysfunction from encephalitis episode in 2023. Since then patient has had difficulty finding work. Please facilitate his early release of superannuation to reduce the risk of further financial difficulties.

2. In accordance with the Superannuation Industry (Supervision) Act 1993 and Regulations and taxation law covering payment of benefits due to permanent incapacity, I certify that in my opinion, the above named member is unlikely ever again to engage in gainful employment for which he/she is reasonably qualified by education, training or experience.
3. I confirm I am a legally qualified medical practitioner registered with the Australian Health Practitioner Regulation Authority (Ahpra) and provide my registration details below.

### Signature of person making the declaration

															Date				
															04/03/2025				
Last name															Mr	Mrs	Ms	Miss	Dr
L E O N G															<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
First name/s																			
H S I E N																			
Street address																			
501A High Street																			
Suburb/Town										State		Postcode							
N O R T H C O T E										V I C		3 0 7 8							
Phone number					Provider number														
0398287575					447712CK														
Ahpra Registration Number																			
M E D 0001665273																			
Qualifications																			
F R A C G P																			

## Privacy Collection Statement

Please read this Privacy Collection Statement to see how AustralianSuper uses your personal information.

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