

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: **B O T T E R I L L** Mr Mrs Ms Miss Dr

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: **N O R T H C O T E** State: **V I C** Postcode: **3 0 7 0**

Date of birth: **2 3 1 2 1 9 8 8** Member Number: **1 0 7 4 4 3 7 3 2 7** Male Female

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:

Herpes simplex encephalitis cause permanent memory loss and depression

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

[Handwritten Signature]

Date: **1 3 0 3 2 0 2 5**

Last name: **M A H M O D** Mr Mrs Ms Miss Dr

First name/s: **A H M E D**

Street address: **5 5 3 B A L W Y N R O A D**

Suburb/Town: **B A L W Y N N O R T H** State: **V I C** Postcode: **3 1 0 9**

Phone number: **0 3 9 8 5 7 7 4 1 7** Provider number: **2 3 0 2 6 3 F W**

Ahpra Registration Number: **M E D 0 0 0 1 1 9 1 5 1 7**

Qualifications: **F R A C G P**