



Your Confidential Medical and Personal Statement (CMAPS)

Instructions

This form must not be completed until you become a member of the PSS.

As a new member of the Public Sector Superannuation Scheme (PSS) you are required to complete a Confidential Medical and Personal Statement (CMAPS) and forward it to your Personnel Officer within 14 days of becoming a member of the Scheme. Your answers will assist in deciding whether your health is sufficiently sound that you could be expected to complete three-years' membership without taking excessive sick leave. If your health is not sufficiently sound you will be declared a Limited Benefits Member (LBM) of the Scheme.

You should read the **PSS Product Disclosure Statement** available at www.pss.gov.au for further information regarding LBM status. Your employer may require you to have a medical examination for employment purposes. This CMAPS is not used to decide whether or not you are to remain employed or a member of the Scheme.

When you have completed your CMAPS you should return it to your personnel office within 14 days of the date you became a member of the PSS. Normally the statement will be retained by your personnel office and stored on your personal file. It may, however, be sent to ComSuper if clarification of any aspect is required.

If the statement is not completed and sent within the 14-day period, you will be regarded as a LBM until a completed statement is received and your medical status is decided.

If you are classified as a LBM due to medical reasons, advice will be sent to your nominated private address. If further medical information is required, you will be contacted at your private address.

If you have any queries, please telephone your personnel office.

How to complete the statement

Please use **black** ballpoint pen. Some questions only need a cross in one of the answer boxes. Please use a 'cross' in the appropriate box like this:

Yes

No

Other questions require a hand printed answer using CAPITAL LETTERS like this:

Address

C	O	M	S	U	P	E	R													
P	O		B	O	X		2	2												
SUBURB														STATE				POST CODE		
B	E	L	C	O	N	N	E	N						A	C	T	2	6	1	6

Privacy

ARIA and our administrator, ComSuper, are committed to protecting any information you give us. Your information will be used to assess the level of your health and to contact you if we need to in the future.

Your information will not be used for any other purpose or disclosed to another party, unless:

- > it is to Health Services Australia or other approved medical practitioners if we need to seek medical opinions in relation to your membership status
- > you authorise us to do so
- > it is required by law.

Personal statement of medical history

Important notice

Ensure you have read the instructions on the cover sheet.

CMAPS WILL BE CONSIDERED INCOMPLETE IF AGS NUMBER IS NOT PROVIDED.

Note that under the provisions of the *Superannuation Act 1990*, if it is discovered that a member either:

- fails to fully and honestly disclose any information required; or
- gives any incorrect or misleading information;

the member may be treated as a Limited Benefits Member.

As a result, such a member may receive reduced benefits should they die or retire on invalidity grounds within the first three years of Scheme membership.

SECTION A Personal 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"/> ^Y
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address	<input type="text"/>
	<input type="text"/>
	SUBURB <input type="text"/> STATE <input type="text"/> POST CODE <input type="text"/>
Phone number	<input type="text"/> <input type="text"/>
Employer	<input type="text"/>
Employer's business address	<input type="text"/>
	<input type="text"/>
	SUBURB <input type="text"/> STATE <input type="text"/> POST CODE <input type="text"/>
Personnel section phone number	BUSINESS HOURS <input type="text"/>

SECTION B Declaration

I understand that:

- any incorrect or misleading statements or omissions in this statement could affect the level of any death or disability benefit that may become payable
- I may be requested to authorise any doctor who has attended or examined me, or whom I have consulted, to disclose in writing, information concerning my health
- ComSuper may require further information to determine my PSS benefit status.

I declare that:

- all answers in this statement are true and correct to the best of my knowledge and belief
- I have not failed to supply any information required and have not provided false information.

MEMBER'S SIGNATURE

Date signed

^D	^D	/	^M	^M	/	^Y	^Y	^Y	^Y
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OFFICE USE ONLY

G. Who is your usual doctor? (Your doctor will not be contacted without your written permission)

Surname

Given name(s)

Address

SUBURB

STATE

POST CODE

How long have you
been their patient? weeks months years**H.** Has your weight altered substantially in the last 12 months? No Yes—please give details and reasons. kg increase decrease

REASON

I. State your height (without shoes) and current weight (unclothed).Height cmWeight kg**J.** During the LAST 5 YEARS have you had a continuous absence of more than one week from work, school, college or university for any health related reasons? No Yes—please give details, including reasons and dates.

CONTINUOUS ABSENCES

K. Do you consume alcohol? No Yes—please give the average daily quantity. mL**L.** Do you smoke or have you ever smoked? No Yes—please specify in what form and daily quantity? per day

FROM

Section C continued on next page

If insufficient space, provide further details to Yes answers on a separate page and enclose with the completed form.

Instance 2

DATE OF EXAMINATION
 D D M M Y Y Y Y
 / /

FULL NAME OF DOCTOR

DOCTOR'S ADDRESS

SUBURB STATE POST CODE

REASON FOR MEDICAL CONSULTATION, MEDICATION OR TREATMENT

RESULTS OF ANY TEST

DATE OF COMPLETE RECOVERY
 D D M M Y Y Y Y
 / /

DURATION
 D D M M Y Y Y Y to D D M M Y Y Y Y
 / / to / /

For Section 3P to 3AI, in the last 5 years have you had medical advice or treatment for any of the following? If Yes, provide full details, including nature and duration of illness, dates and name and address of doctors, hospitals, chiropractors, physiotherapists, etc. concerned.

P. Mental or nervous condition, anxiety state or any depression?
 No
 Yes—please give full details.
 DETAILS

T. Indigestion, gastric, peptic or duodenal ulcer?
 No
 Yes—please give full details.
 DETAILS

Q. Asthma, tuberculosis, bronchitis, emphysema or any other lung illness?
 No
 Yes—please give full details.
 DETAILS

U. Bowel disease?
 No
 Yes—please give full details.
 DETAILS

R. High blood pressure, rheumatic fever, heart murmur or any heart complaint?
 No
 Yes—please give full details.
 DETAILS

V. Hepatitis, or any liver or gall bladder disease?
 No
 Yes—please give full details.
 DETAILS

S. Pain in the chest or difficulty breathing?
 No
 Yes—please give full details.
 DETAILS

W. Epilepsy, fainting attacks or fits of any kind?
 No
 Yes—please give full details.
 DETAILS

Section C continued on next page

If insufficient space, provide further details to Yes answers on a separate page and enclose with the completed form.

X. Headaches or migraine?

No

Yes—please give full details.

DETAILS

Y. Kidney or bladder disease, including renal colic or stone in the bladder?

No

Yes—please give full details.

DETAILS

Z. Cancer or tumour of any type?

No

Yes—please give full details.

DETAILS

AA. Arthritis, gout or joint pains (e.g. shoulder, hand, knee, ankle, hip), RSI, tenosynovitis or any other disorder of muscles, joints or bones?

No

Yes—please give full details.

DETAILS

AB. Any neck or back complaint, pain or injury?

No

Yes—please give full details.

DETAILS

AC. Any blood disorder?

No

Yes—please give full details.

DETAILS

AD. Coughing blood, passing blood from the bowel or in the urine?

No

Yes—please give full details.

DETAILS

AE. Any defects in sight, speech, hearing, or any ear discharge?

No

Yes—please give full details.

DETAILS

AF. Sugar in the urine, or diabetes?

No

Yes—please give full details.

DETAILS

AG. Any skin disorders?

No

Yes—please give full details.

DETAILS

AH. Have you been diagnosed as having AIDS or any AIDS-related condition?

No

Yes—please give full details.

DETAILS

AI. Any other illness, or any other accident, injury or operation?

No

Yes—please give full details.

DETAILS

AJ. Do you have any health problems or concerns which are NOT mentioned in any other questions on this statement or which relate to your health **more than five years ago**?

No

Yes—please give full details.

DETAILS

AK. Do you contemplate having an operation or being hospitalised in the future?

No

Yes—please give full details.

DETAILS

..... END FORM

If insufficient space, provide further details to Yes answers on a separate page and enclose with the completed form.