State Sector Retirement Savings Scheme Registered Medical Report



To be attached to a SuperLife Superannuation Master Trust Withdrawal Request Form. Please return this completed form together with any supporting evidence to: superlife@superlife.co.nz or post to: SuperLife Superannuation Master Trust, PO Box 105262, Auckland 1143. For any questions, please call us on 0800 27 87 37 or +64 9 375 9800 if you're calling us from overseas.

Member number	Plan name
Member's full name	
SECTION 2: PATIENT DETAILS	
SECTION 2. FAITENT DETAILS	
Title (Mr, Mrs, Miss, Ms, Mx, Dr or Other)	Date of birth
First names	Surname
Home address	
Tiome address	
Street address	
Street address	
Street address Suburb	Postcode

Title (Mr, Mrs, Miss, Ms, Mx, Dr or Other)	
irst names	Surname
Work address	
Street address	
Suburb	
Town/city	
Country	Postcode
Contact daytime telephone	Email (optional)
lease answer the questions below and, rovided below:	where applicable, give a reason for your answer in the space arry, illness or disability that the member suffers from.
rovided below:	where applicable, give a reason for your answer in the space
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SECTION 4: MEDICAL QUESTIONNAIRE (CONTINUED)

No – go to question 4.3	Yes – please provide explanation below of the basis on which you have formed this opinion and then go to section 5
	have formed this opinion and their go to section o
	ess or disability the member suffers from, is the member totally and
nanently unable to engage in	n work that he/she is suited by reason of experience, education or traini
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SECTION 5: MEDICAL DECLARATION

I certify that:

- 1. I am a health practitioner registered with either the Medical or the Nursing Council of New Zealand and the assessment covered by this certification is within my scope of practice.
- 2. The answers given in 2–4 are true and correct.



Important: When returning this form, please also attach copies of any other relevant medical/hospital reports and test results.