Australian Government
Commonwealth Superannuation Corporation

PSS | Public Sector Superannuation Scheme

CMAPS
08/04

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:

[X] Yes
[ ] No

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

Address: COMSUPER
PO BOX 2252

SUBURB: CANBERRA CITY | STATE: ACT | POST CODE: 2601

Privacy

The Commonwealth Superannuation Corporation (CSC) 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 Medibank Health Solutions 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.

Your Government Super at Work

Any financial product advice in this document is general advice only and has been prepared without taking account of your personal objectives, financial situation or needs. Before acting on any such general advice, you should consider the appropriateness of the advice, having regard to your own objectives, financial situation or needs. You may wish to consult a licensed financial advisor. You should obtain a copy of the PSS Product Disclosure Statement and consider its contents before making any decision regarding your super.

Commonwealth Superannuation Corporation (CSC) ABN: 48 882 817 243 AFSL: 238069
RSEL: L0001397 Trustee of the Public Sector Superannuation Scheme (PSS) ABN: 74 172 177 893 RSE: R1004595

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:

a) fails to fully and honestly disclose any information required; or

b) 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)

Salutation ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other

Surname

Given name(s)

Date of birth D D / M M / Y Y Y Y

Gender ☐ Male ☐ Female

Address

SUBURB STATE POST CODE

Phone number

Employer

Employer's business address

SUBURB STATE POST CODE

Personnel section phone number BUSINESS HOURS

SECTION B Declaration

I understand that:

a) any incorrect or misleading statements or omissions in this statement could affect the level of any death or disability benefit that may become payable

b) 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

c) ComSuper may require further information to determine my PSS benefit status.

I declare that:

a) all answers in this statement are true and correct to the best of my knowledge and belief

b) 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

OFFICE USE ONLY

SECTION C Confidential Medical and Personal Statement

A. (a) On what date did you commence your current employment?

D D / M M / Y Y Y Y

(b) Please provide a brief description of duties

DESCRIPTION OF DUTIES

B. Are you already a contributing member of the PSS (1990 Scheme) or CSS (1976 Scheme) in relation to other employment?

- [ ] No
- [ ] Yes

C. What is your employment status? (choose one)

- [ ] Permanent
- [ ] Casual
- [ ] Temporary

D. Are you currently, or have you ever been, in receipt of a pension for any health related reasons?

- [ ] No
- [ ] Yes—please give details including type of pension, and start and finish dates

TYPE OF PENSION

START DATE D D / M M / Y Y Y Y to FINISH DATE D D / M M / Y Y Y Y

E. Have you EVER received other payment (excluding Medicare type payment) as a result of accident, sickness or disablement from an insurance company, superannuation fund, government institution, or made a claim on an employer for Work Care, or workers' or accident compensation?

- [ ] No
- [ ] **Yes**—please give details including reasons, approximate start/finish dates.

PAST PAYMENT DETAILS

START DATE D D / M M / Y Y Y Y to FINISH DATE D D / M M / Y Y Y Y

F. Has any proposal to insure you for life, sickness or disability insurance, or superannuation, EVER been accepted on special terms, deferred or declined?

- [ ] No
- [ ] **Yes**—please give details, including dates.

PAST INSURANCE CLAIM 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.

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 cm Weight 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.

M. Are you now using or have you ever used any mood altering substances (stimulants or sedatives) or any drugs requiring a doctor's prescription without obtaining the doctor's prescription?

☐ No

☐ **Yes**—please give details.

REASON

N. Have you had any blood test which showed any abnormality? (e.g. high blood glucose, hepatitis B antibodies, HIV antibodies).

☐ No

☐ **Yes**—Please give full details, including reasons for the test, the result and date.

REASON AND RESULT

D D / M M / Y Y Y Y

O. During the LAST 5 YEARS have you had any medical examination or treatment (including treatment by a physiotherapist or chiropractor), been in hospital, been advised to have an operation or had any test such as an X-ray, electrocardiogram, CAT scan etc?

☐ No

☐ **Yes**—please provide full details of each instance below.

Instance 1

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

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

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

Q. Asthma, tuberculosis, bronchitis, emphysema or any other lung illness?

- [ ] 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

S. Pain in the chest or difficulty breathing?

- [ ] No
- [ ] **Yes**—please give full details.

DETAILS

T. Indigestion, gastric, peptic or duodenal ulcer?

- [ ] No
- [ ] **Yes**—please give full details.

DETAILS

U. Bowel disease?

- [ ] No
- [ ] **Yes**—please give full details.

DETAILS

V. Hepatitis, or any liver or gall bladder disease?

- [ ] 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.