Australian Government
Commonwealth Superannuation Corporation

CMAPS 07/19

Confidential Medical and Personal Statement (CMAPS)

Important information about this form

Instructions for employers

You must give a **Confidential Medical and Personal Statement (CMAPS)** form to **every** employee who is re-entering the Public Service Superannuation Scheme (PSS), and on **every** occasion they're re-employed under a new AGS number. You must ensure that the new AGS number is included on the **CMAPS** form.

A note must be attached to their personal file stating that they've been given a **CMAPS** form and the date it was provided. You must inform them that they're obliged to complete and return this form to us within 14 days, otherwise they will automatically become a Limited Benefits Member (LBM).

Information for members

As a new employee re-entering PSS you must complete this **CMAPS** form and return it to us within 14 days from your commencement date. Your answers on this form will be assessed against the Superannuation Entry Medical Standard (SEMS) to determine whether your health will allow you to complete your first three years of membership without taking excessive sick leave. If your health is not sufficiently sound you will be classified as a LBM.

LBM status means you won't be eligible to apply for pre-assessment payments or partial invalidity pension. Any death or invalidity benefits payable within the first three years of membership would be reduced on medical grounds. For more information about your LBM status you should read the **PSS Product Disclosure Statement (PDS)** available online at **csc.gov.au**

If you don't complete and return this form within 14 days you will automatically be classified as a LBM. You'll remain a LBM until your completed **CMAPS** form is returned and your medical status determined.

If you've been classified as a LBM for medical reasons you'll be notified at your private address and be provided with reasons and appeal provisions. If you've automatically been classified as a LBM, you'll also be notified and given another opportunity to fulfil your obligation to complete a **CMAPS** form.

If it's discovered that you've failed to fully and honestly disclose, or gave incorrect or misleading information, under non-disclosure provisions contained within the *Superannuation Act 1990* you **may be made a LBM at the time of your claim**. Any death or invalidity benefits payable within the first three years of membership would receive reduced benefits.

This **CMAPS** form is not connected with any other medical assessment your employer may require for employment purposes. It's relevant only to your medical status within PSS.

Public Sector Superannuation Scheme

The information provided 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 and needs. You may wish to consult a licensed financial advisor. You should obtain a copy of the PSS Product Disclosure Statement (PDS) 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

How to use this form

Please use CAPITAL LETTERS and a black or blue pen.

Mark boxes like this ☐ with a ✓ or ✗ then fill out the next question or section.

Submitting your form

Please send your completed form to us:

Post: **PSS**
GPO Box 2252
Canberra
ACT 2601
AUSTRALIA

Alternatively, you can scan and e-mail the completed **CMAPS** form to:
formsandapplications@csc.gov.au

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

Address

SUBURB STATE POSTCODE

Email

@

Phone number

Employer

Employer's business address

SUBURB STATE POSTCODE

Personnel section phone number BUSINESS HOURS

B 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 your duties.

DESCRIPTION OF DUTIES

B.

Are you already a contributing member of 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

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

Section B continued on next page

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

G.

Has your weight altered substantially in the **last 12 months**?

☐ No

☐ **Yes** – please give details and reasons.

___ . _ kg ☐ increase ☐ decrease

REASON

H.

State your height (without shoes) and current weight (unclothed).

Height ___ cm Weight ___ kg

I.

During the **last five 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

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

Section B continued on next page

J.

Do you consume alcohol?

- [ ] No
- [ ] **Yes –** please give the average daily quantity.

☐☐☐ mL

K.

Do you smoke or have you ever smoked?

- [ ] No
- [ ] **Yes –** please specify in what form and daily quantity?

☐☐☐ per day

FROM

L.

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

M.

Have you had any blood test which showed any abnormality? (eg 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

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

Section B continued on next page

N.

During the **last five 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

POSTCODE

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

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

Section B continued on next page

Instance 2

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

FULL NAME OF DOCTOR

DOCTOR'S ADDRESS

SUBURB

STATE

POSTCODE

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

In the last five 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.

O.

Mental or nervous condition, anxiety state or any depression?

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

DETAILS

P.

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

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

DETAILS

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

Section B continued on next page

Q.

High blood pressure, rheumatic fever, heart murmur or any heart complaint?

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

DETAILS

R.

Pain in the chest or difficulty breathing?

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

DETAILS

S.

Indigestion, gastric, peptic or duodenal ulcer?

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

DETAILS

T.

Bowel disease?

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

DETAILS

U.

Hepatitis, or any liver or gall bladder disease?

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

DETAILS

V.

Epilepsy, fainting attacks or fits of any kind?

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

DETAILS

W.

Headaches or migraine?

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

DETAILS

X.

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

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

DETAILS

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

Section B continued on next page

Y.

Cancer or tumour of any type?

☐ No

☐ **Yes** – please give full details.

DETAILS

Z.

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

☐ No

☐ **Yes** – please give full details.

DETAILS

AA.

Any neck or back complaint, pain or injury?

☐ No

☐ **Yes** – please give full details.

DETAILS

AB.

Any blood disorder?

☐ No

☐ **Yes** – please give full details.

DETAILS

AC.

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

☐ No

☐ **Yes** – please give full details.

DETAILS

AD.

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

☐ No

☐ **Yes** – please give full details.

DETAILS

AE.

Sugar in the urine, or diabetes?

☐ No

☐ **Yes** – please give full details.

DETAILS

AF.

Any skin disorders?

☐ No

☐ **Yes** – please give full details.

DETAILS

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

Section B continued on next page

AG.

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

☐ No

☐ **Yes** – please give full details.

DETAILS

AH.

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

☐ No

☐ **Yes** – please give full details.

DETAILS

AI.

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

AJ.

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

☐ No

☐ **Yes** – please give full details.

DETAILS

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

C 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
- PSS may require further information to determine my 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

OFFICE USE ONLY

D Lodgement

You have now completed this form.

Please send your completed form to us:

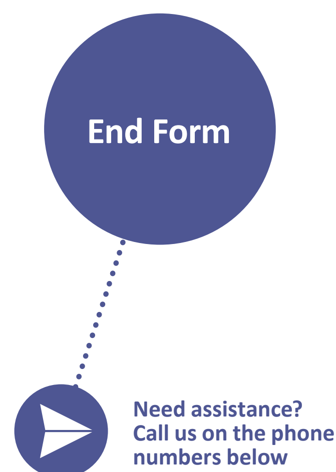
Post: **PSS**
GPO Box 2252
Canberra
ACT 2601
AUSTRALIA

Alternatively, you can scan and e-mail the completed **CMAPS** form to:
formsandapplications@csc.gov.au

Privacy

Personal information that you or a third party provide, such as your employer, is collected, held, used and disclosed as required or authorised by law in accordance with the privacy policies and notice, available via **csc.gov.au** or by contacting us on **1300 000 377**, for the purpose of managing your super. This includes the management of superannuation investments, providing superannuation products and information, the administration of accounts, conducting market research and product development. The privacy policies and notice contain important information about how personal information is handled, including rights to access and update that information and how a complaint about a breach of privacy can be made.

You should check that the information provided is correct and complete, as if it is discovered that you've failed to fully and honestly disclose, or gave incorrect or misleading information, under non-disclosure provisions contained within the *Superannuation Act 1990* you may be made a LBM at the time of your claim. For more information, including how to make a complaint regarding privacy, refer to the privacy policies and notice available via **csc.gov.au**



Need assistance? Call us on the phone numbers below