



Benefit estimate request form

Agency

Address

 STATE POSTCODE

Contact person

Phone

Fax

Email

I confirm the member (or the member's immediate family in the event of death) is aware this information is being sought and the member (or the member's immediate family in the event of death) has given consent to its disclosure to the agency.

SIGNATURE OF AUTHORISED OFFICER

DATE

 DAY / MONTH / YEAR

Type of exit (please tick one)

Age Resignation Involuntary reirement Invalidity > Sick leave start date:
 DAY / MONTH / YEAR
Death > Please tick as applicable: Potentially eligible spouse exists Potentially eligible children exist

Estimate to be returned by:

 Agency email Fax Member email (please specify on page 2) Post

