



Benefit estimate request form

Agency	<input type="text"/>
Address	<input type="text"/>
	<input type="text"/>
	SUBURB <input type="text"/> STATE <input type="text"/> POST CODE <input type="text"/>
Contact Person	<input type="text"/>
Phone	<input type="text"/>
Fax	<input type="text"/>
Email	<input type="text"/>
	@ <input type="text"/>

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

SIGNATURE

Date signed

^D ^D / ^M ^M / ^Y ^Y ^Y ^Y

Type of exit (please tick one)

- Involuntary reirement
 Resignation
 Age

Invalidity > Sick leave start date:

^D ^D / ^M ^M / ^Y ^Y ^Y ^Y

Death > Please tick 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

