Contact Details for Future Super

Fund ABN	68 964 712 340 | USI 68964712340019
Phone	1300 658 422
Email	info@futuresuper.com.au
Web	www.futuresuper.com.au
Post	GPO Box 2754, Brisbane QLD 4001

Application for Early Release of Super due to Permanent Incapacity

Issue date: 1 November 2026

Complete this form to apply to make a withdrawal from your Future Super account due to permanent incapacity.

You can find detailed information about Future Super in our Product Disclosure Statement (PDS), How Future Super Works Guide, Insurance Guide, Financial Services Guide and Privacy Policy, all of which can be obtained from www.futuresuper.com.au or on request by phoning 1300 658 422.

This form must be posted to GPO Box 2754, Brisbane QLD 4001.

Section 1: Personal Details

Given Name(s)

Surname

Member Number

Date of Birth

Mobile Phone Number

Email Address[1]

Residential Address City State Postcode

[1] By providing your email address, you consent and authorise us to send you communications or information, including information required by law, email or similar technologies. Your details will never be passed onto a third party other than in accordance with our Privacy Policy. You can elect to receive communications by post at any time by contacting Future Super on 1300 658 422 or via email at info@futuresuper.com.au or in writing at GPO Box 2754, Brisbane QLD 4001.

Issued by Stewarda Pty Ltd ABN 56 098 527 256, AFSL 236049, RSE Licence L0000185 as trustee of the Smart Future Trust ABN 68 964 712 340, RSE Registration No R1000566 (the Fund). Future Super is a product in the Fund.

Section 2: Occupation Status

Please advise the occupations that you have undertaken that best reflect your education, training and experience.

Occupation 1

Occupation 2

Occupation 3

Last employer's name

Date last worked for employer

Employers Address City State Postcode

'Permanent incapacity' refers to the early release of your preserved superannuation benefit on the grounds of illness or injury which renders you unlikely to ever again engage in gainful employment for which you are reasonably qualified by education, training or experience.

Have you permanently ceased all employment? Yes ☐ No ☐

If you answer 'no' to this question, you cannot make a claim for early release of your superannuation because of permanent incapacity.

Section 3: Diagnosis

Please list all medical conditions (illness, injury or disability) which impact on your capacity to work:

Section 4: Withdrawal Information

Do you wish to withdraw your entire account balance?[2] Yes ☐ No ☐

If no, how much would you like to withdraw? $

If approved, the withdrawal payment will be made into the account you specify below:

Account Name[3]

Name of Financial Institution

BSB

Account Number

Section 5: Verification of Identity

Please select one of the two options below.

☐ Option 1 – I want to attach paper copies of certified ID

Please ensure that you provide photocopies of your original identification documents and that they are correctly certified. Each page must be certified as a true copy.

If the documents you provide are not correctly certified or are unable to be read you authorise us to validate your identity and perform an anti-money laundering and counter terrorism financing check using a third party green ID validation provider, including confirming your document is valid with the original document issuer.

Some of the people who can certify copies of originals as true copies in Australia are:

- a medical practitioner
- a nurse
- a veterinary surgeon
- an optometrist
- an accountant (member of CA, CPA or IPA)
- a psychologist
- a police officer
- a pharmacist
- a legal practitioner
- a chiropractor
- a Justice of the Peace
- a judge or magistrate
- a dentist
- a physiotherapist
- a chief executive officer of a Commonwealth court

[2] If you withdraw your entire account balance any insurance cover you hold with Future Super will cease and your account will be closed.

[3] We can only make payments into an Australian bank, credit union or building society account that's in your name or held jointly in your name with another person.

• a teacher employed on a full-time basis at a school or tertiary institution

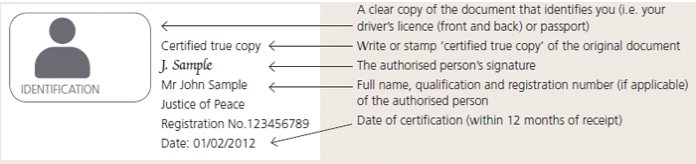
• an employee with two or more years' continuous service with an office supplying postal services to the public

• an officer with, or authorised representative of, a holder of an Australian Financial Services Licence (AFSL), having two or more years continuous service with one or more licensees

The person authorised to sight and certify documents must:

- Sight the original and the copy and make sure they are identical; and
- Write or stamp 'certified true copy' on all copied pages followed by their signature, printed name, qualification (e.g. Justice of the Peace), registration number (if applicable) and date.

For example:



☐ Option 2 – I want to use electronic verification

By providing the information below, you authorise us to validate your identity and perform an anti-money laundering and counter terrorism financing check using a third-party identification validation provider, including confirming your document is valid with the original document issuer.

You must provide at least two of the following (if you are unable to provide this information you will need to provide certified ID as per option 1):

Australian Passport

(Please complete the details exactly as they appear on your Passport)

Passport Number	Date of Birth
First and middle names (if applicable)	Sex
Last Name	

Medicare Card

(Please complete the details exactly as they appear on your card)

Card Number	Date of Birth
First and middle names (if applicable)	Reference Number
Last Name	Card Expiry Date

Australian Driver's License

(Please complete the details exactly as they appear on your card)

License Number	Last Name
Card Number	Date of Birth
First and middle names (if applicable)	State of Issue

Section 6: Declaration and Signature

By completing this form, I declare that:

- The information I have given on this form and accompanying information provided in the medical reports and the Statutory Declaration is true and correct.
- I have made an informed decision because I have read and understand the Future Super Product Disclosure Statements (PDS) and related documents.
- I acknowledge that the Trustee cannot provide me with financial advice about the consequences of paying out my benefit and that I should consult an appropriately qualified adviser for such advice.
- I understand that I can request appropriate information that I may reasonably require from the Fund for the purpose of understanding my benefit entitlement, including information about fees and charges that may apply.
- I accept that I am bound by the provisions of the trust deed and rules which govern the operation of Future Super.
- I have read and understood the Privacy Statement and understand how Future Super will use my personal information.

Signature

Print Name Date

Processing Checklist

The Trustee will not begin assessing your application until all of the following have been received:

☐ Form completed and signed	☐ Verification of ID completed
☐ Statutory declaration completed and signed	☐ Medical reports completed by two independent registered medical practitioners

PRIVACY STATEMENT: By signing this form you consent to Future Super collecting and using your personal information to manage your superannuation account and to comply with the relevant legislation. If you do not provide this information, we may not be able to accurately manage your superannuation account. Your personal information may be disclosed to other parties, including the Trustee, the Fund Promoter, the Fund's Administrator, the Fund's Insurer and professional advisers, government bodies and the trustee of any other fund to which you transfer. To access your personal information or for a copy of our Privacy Policy, visit www.futuresuper.com.au or phone 1300 658 422

Medical Report Form for Permanent Incapacity claim

This form must be completed by a registered medical practitioner.

Member Name | Member Number

This member has applied for the early release of their superannuation benefit on the grounds of permanent incapacity. Please complete this report as fully as possible and if necessary, provide additional sheets for further information.

The member is responsible for any costs associated with obtaining this report.

Are you the member's usual medical practitioner? Yes ☐ No ☐

What is the nature of the member's present disability?

Please provide details of the member's present medical condition and, if available, the history of the disability.

When did the member first consult you regarding the disability? Date

What treatment is the member currently receiving in relation to the disability?

The definition of Permanent Incapacity requires the Trustee to be reasonably satisfied that the member is suffering from ill health (whether physical or mental), to such an extent that the member is unlikely, because of the ill health, to ever engage in gainful employment for which the member is reasonably qualified by education training or experience.

In your opinion, does the member meet the above definition? Yes ☐ No ☐

If the member does meet the above definition of permanent incapacity, please provide your detailed explanation as to why below.

If, in your opinion, the member is not permanently incapacitated, please indicate the nature of any employment that might be open to them.

Additional comments:

I hereby certify that I have examined the above named Future Super member and that the statements made in this Medical Report are true and correct to the best of my knowledge.

Name

Qualifications

Provider Number Phone Number

Email Address

Signature

Print Name Date

Medical Report Form for Permanent Incapacity claim

This form must be completed by a registered medical practitioner.

Member Name | Member Number

This member has applied for the early release of their superannuation benefit on the grounds of permanent incapacity. Please complete this report as fully as possible and if necessary, provide additional sheets for further information.

The member is responsible for any costs associated with obtaining this report.

Are you the member's usual medical practitioner? Yes ☐ No ☐

What is the nature of the member's present disability?

Please provide details of the member's present medical condition and, if available, the history of the disability.

When did the member first consult you regarding the disability? Date

What treatment is the member currently receiving in relation to the disability?

The definition of Permanent Incapacity requires the Trustee to be reasonably satisfied that the member is suffering from ill health (whether physical or mental), to such an extent that the member is unlikely, because of the ill health, to ever engage in gainful employment for which the member is reasonably qualified by education training or experience.

In your opinion, does the member meet the above definition? Yes ☐ No ☐

If the member does meet the above definition of permanent incapacity, please provide your detailed explanation as to why below.

If, in your opinion, the member is not permanently incapacitated, please indicate the nature of any employment that might be open to them.

Additional comments:

I hereby certify that I have examined the above named Future Super member and that the statements made in this Medical Report are true and correct to the best of my knowledge.

Name

Qualifications

Provider Number Phone Number

Email Address

Signature

Print Name Date

Early Release of Benefit due to Permanent Incapacity - Statutory Declaration

I (Name)

of (Address)

as a (Occupation)

do solemnly and sincerely declare that the information provided by me in the 'Application for Early Release of Super due to Permanent Incapacity Form' annexed to this Statutory Declaration is true and correct.

I declare that I have permanently ceased employment due to my illness/injury, resulting in my inability to be employed ever again in any capacity for which I am reasonably qualified by education, training or experience.

I make this solemn declaration by virtue of the Statutory Declaration Act 1959 as amended (the Act) and subject to the penalties[4] provided in that Act for the making of false statements in the statutory declarations, conscientiously believing the statements contained in the declaration to be true in every particular.

Signature of person making the declaration — Please sign in front of an authorised witness.

Declared at — Location

On — Date

Authorised witness before me — (Name of authorised witness) Please print.

Signature of authorised witness

Qualifications of authorised witness

Please provide a wet signature (signed with a blue or black pen).
We do not accept electronic signatures.

[4] A person who intentionally makes a false statement in a Statutory Declaration made under the Statutory Declaration Act 1959 (as amended) is guilty of an offence against this Act, the punishment for which is a fine not exceeding $200 or imprisonment for a term not exceeding 6 months or both if the offence is prosecuted summarily, or imprisonment for a term not exceeding four years if the offence is prosecuted upon indictment.