



# Service Pension Claim Invalidity Details

## Privacy notice

Your personal information is protected by law, including the *Privacy Act 1988*. Your personal information may be collected by the Department of Veterans' Affairs (DVA) for the delivery of government programs for war veterans, members of the Australian Defence Force, members of the Australian Federal Police and their dependants.

[Read more: How DVA manages personal information](#)

### NOTE:

The information sought on this form and on any additional forms is required to assess your eligibility for a benefit under the *Veterans' Entitlements Act 1986*. It may also be used to determine eligibility for benefits under the *SRC Act 1988*.

For invalidity service pension purposes, a person is considered to be permanently incapacitated for work if the person:

1. is permanently blind in both eyes; or
2. is eligible for the Special Rate of disability pension (T&PI) under the *Veterans' Entitlements Act 1986* or Special Rate Disability Pension (SRDP) under the *Military Rehabilitation and Compensation Act 2004* (MRCA); or
3. has a disability(ies) that permanently prevents them from working.

A person who is not blind or eligible for T&PI or SRDP must satisfy the following criteria to be considered to have disability(ies) that prevent them from working. The disability(ies) do not need to be related to military service:

- the person has a disability(ies) that results in a combined impairment rating of 40 points or more using the *Guide to the Assessment of Rates of Veterans' Pensions (GARP)* **and**
- the incapacity from the disability(ies) alone, permanently prevents the person from working for periods adding up to more than 8 hours per week, **and**
- the disability(ies) are permanent.

### Your details

Please write in BLOCK LETTERS using a blue or black pen (not pencil)

1. Your surname
2. Given name(s)
3. Residential address   
 Postcode
4. Date of birth  /  /
5. DVA file no. (if known)
6. Are you currently working?  Yes - I am currently working  hours per week.  
 No - I ceased working on  /  /

### Declaration and authority

- I declare that the information I have given in this form is complete and correct.
- I authorise the Department of Veterans' Affairs to obtain medical or other information needed to process my claim for invalidity service pension.
- I consent to the release of medical, clinical or other information to the Department by any medical practitioner, hospital, clinic, insurance company, Australian Government Departments or agencies (*including Centrelink*) and other organisations, in relation to this claim.

### Signature

Date

 /  /

DVA file no. (if known)

**This column is to be completed by the veteran**

List only the disabilities or symptoms that are permanently preventing you from working.

**Disability and/or symptom**

**How this disability prevents you from working:**

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**Disability and/or symptom**

**How this disability prevents you from working:**

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**Important**

So that your claim can be processed quickly:

- please have your doctor provide a diagnosis for each disability preventing you from working; and
- provide all relevant documents you may have relating to your disabilities.

**This column is to be completed by the treating medical practitioner.**

For each disability the veteran has listed, please provide a diagnosis. Please also supply a brief summary of the evidence upon which each diagnosis is based. The Department will pay you for this service according to the attached Schedule of Fees. An account must be lodged before payment can be made.

**Medical diagnosis**

**Evidence**

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.....

**Specialist reports attached?**

Yes  No

**Is the disability:**

Permanent  Temporary  
 Improving  Deteriorating

**If the veteran arrived in Australia in the last 10 years, do you consider the condition existed on arrival?**

Yes  No

**Medical diagnosis**

**Evidence**

.....  
.....

**Specialist reports attached?**

Yes  No

**Is the disability:**

Permanent  Temporary  
 Improving  Deteriorating

**If the veteran arrived in Australia in the last 10 years, do you consider the condition existed on arrival?**

Yes  No

**I have been treating this patient since**

**Doctor's stamp (or address and telephone number)**

**Doctor's signature**

**Date**

Please attach a separate sheet if you need to list more disabilities that are permanently preventing you from working.