ZURICH

Group Risk Insurance
Employer's Statement

Please note:

- Print in black or blue ink.
- Please ensure questions are answered in full where possible. Incomplete and unanswered questions may result in the claim being delayed.
- Attach a separate page if more space for an answer is required and clearly indicate to which question the additional information relates.

Name of Superannuation Fund

Member number

1. Employee details

Title ◯ Mr ◯ Mrs ◯ Ms ◯ Miss Other

Surname

First name(s)

Date of birth / /

2. Employer details

Business name

ABN

Street no. and name

Suburb/Town State Postcode

Phone number Fax number

Employer contact name

Postal address

3. Reason for ceasing work

3.1 What is the reason for the employee ceasing work? ◯ Illness ◯ Injury ◯ Redundancy ◯ Resignation ◯ Termination

3.2 Please provide details for the above. If relevant, please include copies of termination/resignation letter and reasons if related to the claim condition.

4. Employment

4.1 What was the employee's usual occupation? Please also provide a copy of the position description, if available.

4.2 What was the employee's commencement date? (dd/mm/yyyy) / /

What date did the employee cease performing their normal duties? (dd/mm/yyyy) / /

4.3 What was the basis of employment? ◯ Casual ◯ Part-time – permanent ◯ Full-time – permanent ◯ Contractor

Annual salary (gross before tax) $ Hourly rate $

Usual hours worked per week (weekly average over 12 months immediately prior to the injury/illness)

Please note:

- If the employee has been employed for less than 12 months, please complete this question based on the actual period of employment.
- If the employee has been on and off work, please attach a list of the applicable dates or their leave history (including all leave such as sick, annual and long service leave) for the 12 months prior to the employee ceasing work and confirm whether they have returned in a part- or full-time capacity.

5. Work activities

5.1 What were the main duties of the employee's occupation?

5.2 Did the employee reduce their usual hours/duties as a result of the claimed condition prior to ceasing work? ◯ Yes ◯ No

If **yes**, please provide details for the reduced duties/hours including dates commenced and ceased.

5.3 Has the employee returned to work? ◯ Yes ◯ No

If **yes**, when and in what capacity?

Date (dd/mm/yyyy) / /

◯ Casual ◯ Part-time – permanent ◯ Full-time – permanent ◯ Contractor Hours worked per week

Duties, if different from the main duties outlined in question 5.1.

5.4 Have any alternative jobs been offered to the employee? ◯ Yes ◯ No

If **yes**, please provide details.

5.5 If the employee is medically fit, are you able to accommodate a:

◯ Return to part-time work ◯ Return to suitable duties ◯ Return to full-time work

5.6 Is there a Rehabilitation Assessment or Return To Work Program? ◯ Yes ◯ No

If **yes**, please provide the most recent rehabilitation report, including the name and contact details of the rehabilitation provider.

6. Other insurance

6.1 Are you aware of any claim or intended claim by the employee for this injury/illness, from any of the following sources?

Workers' compensation	◯ Yes ◯ No
Motor accident compensation	◯ Yes ◯ No
Other insurance, superannuation fund, or financial institutions	◯ Yes ◯ No
Other	◯ Yes ◯ No

If **yes** to any of the above, please provide details in the below table.

Amount	Date from (dd/mm/yyyy)	Date to (dd/mm/yyyy)	Claim number	Name and contact details of benefits provider
$	/ /	/ /		
$	/ /	/ /		
$	/ /	/ /		
$	/ /	/ /		

Please note: Should you become aware of a claim for other insurance after completing this form, please contact Zurich immediately.

Additional details/comments

Declaration

I declare that I am authorised to answer the above questions on behalf of the Employer and that to the best of my knowledge the information contained in this form is true, complete and correct in every detail. I understand that I can be prosecuted if I make any fraudulent statement. I acknowledge that this information is provided for the purpose of the assessment of a claim under a policy of life insurance with Zurich and that Zurich may provide this form to third parties, such as doctors, deemed necessary by Zurich to assist it in the assessment of the claim. Where this claim is made under a policy of life insurance owned by a superannuation fund, I authorise Zurich to release this form to the trustee of the superannuation fund (where relevant) or the insured member's employer (where relevant).

Name (please print)

Title/Position

Signature

✗ Date (dd/mm/yyyy) / /

Phone: 1800 648 921
Email: group.claims@zurich.com.au
Website: zurich.com.au
GPO Box 75, Sydney NSW 2001

Zurich Australia Limited (Zurich) ABN 92 000 010 195 AFSL 232510

RHEN-018627-2022 569197-1_OPL8475/0822

ZURICH®