ZURICH

Group Risk Claims
Preliminary Member Statement

If there is insufficient space on this form, please use the space at the back of the form or attach a separate page. Please ensure that you identify the question for which the additional information relates to.

This is a claim for (please select the correct box) ○ **IP** **or** ○ **TPD**

Name of plan

Policy number

Name of employer

Title ○ Mr ○ Mrs ○ Ms ○ Miss Other

Surname

First name(s)

Maiden name (if applicable)

Date of birth (dd/mm/yyyy) / / ○ Male ○ Female ○ Non-binary or a gender identity not listed

Height (cm) Weight (kg)

Residential address

Suburb/Town State Postcode

Phone Home Work Mobile

Email

Country of birth Are you a permanent resident of Australia? ○ Yes ○ No

How long have you lived in Australia? Years Months

Language spoken at home

Name of employer at date of disability

Employer location/address

Date last actively at work (dd/mm/yyyy) / /

Gross annual salary immediately prior to ceasing work $ Hours worked/week (e.g. a 38 or 40 hour week)

Were you employed on a permanent or casual basis? ○ Permanent ○ Casual

Occupation

1. Please list the duties of your occupation and % of time spent performing each. Please attach a full copy of you résumé.

Duty	% of time	Duty	% of time

2. Cause of disablement and/or reason for ceasing work.

◯ Injury ◯ Illness ◯ Redundancy ◯ Resignation ◯ Termination

Please provide details.

3. If an accident, please provide details including how, where and when the accident occurred. Please include the name and contact numbers of any witness and also attach any relevant police/incident reports etc.

4. If an illness, have you had this or a similar condition previously?

◯ Yes

◯ No

If **yes**, please provide a brief history.

5. List all the sports, hobbies and activities that you were involved in prior to your disability.

6. When did you first consult a doctor for this condition? (dd/mm/yyyy) / /

7. Please complete the table below with the relevant details of your treating doctors and specialists.

Doctor's name and speciality	Date first consulted (dd/mm/yyyy)	Date last consulted (dd/mm/yyyy)	Surgery address	Phone no.	Referred by	Reason for referral
	/ /	/ /				
	/ /	/ /				
	/ /	/ /				
	/ /	/ /				
	/ /	/ /				
	/ /	/ /				
	/ /	/ /				
	/ /	/ /				

8. If you have been hospitalised as a result of this disability, please provide details. If you were hospitalised for more than three days, please also enclose a copy of the discharge summary.

Name and address of hospital	Date admitted (dd/mm/yyyy)	Date discharged (dd/mm/yyyy)
	/ /	/ /
	/ /	/ /
	/ /	/ /

9. Please provide details of treatment to date and the results of this treatment (e.g. physiotherapy, medication or surgery etc).

10. Please advise of any proposed treatment together with anticipated dates of commencement.

11. Please complete the following table with full details of any payments you are receiving, are entitled to receive, or are pursuing since the date you last worked. This includes, but is not limited to, any income from other employment, Social Security/Centrelink, Workers' Compensation/Common Law/CTP or other forms of insurance, annual leave, termination pay or any other source of payments. Please attach an itemised list of all payments received.

Source of payments e.g. insurer name and claim no.	Date claim commenced (dd/mm/yyyy)	Date payments commenced (dd/mm/yyyy)	Contact person	Address	Phone no.	Gross weekly amount received
	/ /	/ /				
	/ /	/ /				
	/ /	/ /				
	/ /	/ /				
	/ /	/ /				
	/ /	/ /				
	/ /	/ /				

12. Dates of continuous total disablement due to this current medical condition (i.e. not working in any capacity):

From (dd/mm/yyyy) / / To (dd/mm/yyyy) / /

13. If you are currently disabled, please confirm when you anticipate returning to:

Part-time duties (dd/mm/yyyy) / / Full-time duties (dd/mm/yyyy) / /

14. If you have already returned to work on a part time or restricted basis, please provide details of:

a. date of return to part-time work (dd/mm/yyyy) / /

b. number of hours/week you are currently working

15. If you have returned to work on a full-time basis, please provide date of return to work (dd/mm/yyyy) / /

16. If applicable, please advise the duties you are currently unable to perform.

17. If a rehabilitation assessment/return to work plan has commenced, please complete the following.

Rehabilitation provider	Contact person	Address	Phone no.	Date rehabilitation commenced (dd/mm/yyyy)	Has a return to work plan been completed/ commenced?
				/ /	◯ Yes ◯ No
				/ /	◯ Yes ◯ No

18. If you have not been referred to a rehabilitation provider, are you interested in rehabilitation assistance (i.e. assistance with returning to the workforce)? ◯ Yes ◯ No

If **yes**, please provide details.

19. Employment history

Please put the most recent job at the top and work down to the first job from leaving school.

Period of employment	Employer	Job title	Main tasks	Reason for leaving

20. Please state in your own words how this disability is affecting you and/or make any further comments in relation to this claim.

Please attach the following with your completed form. Please select the box to confirm the attachments.

- ◯ Certified copy of your current driver's licence or passport
- ◯ Hospital discharge summary if appropriate (for hospital stays of more than three days)
- ◯ X-ray and other radiology reports, pathology and other test results
- ◯ Résumé
- ◯ Copies of claim payment letters from other sources
- ◯ Any other information that will assist with your claim.

Please ensure this form is fully completed. Failure to do so may result in the form being returned and a delay in assessing your claim.

Please note you may be required to attend an independent medical examination prior to a determination of your claim.

Declaration and authority:

I hereby declare that I am the person referred to in the above and that the answers are complete and true in every particular.

I authorise:

- Any person, hospital or doctor with whom I have consulted, or any employer, to supply Zurich (or its authorised representative) any information that it may require in the assessment of this claim.
- Any insurer, Centrelink and any other income, pension, annuity and disability support provider to provide Zurich with any information or reports that it requires for the assessment of the claim.
- Zurich to provide any information or document in respect of this claim to the Administrator of the Plan of which I am a member.
- Zurich to provide any information or document to any medical or rehabilitation provider that Zurich deems necessary to assist in the assessment of my disability.
- Zurich (or its authorised representative), where my insurance is linked to my superannuation fund, to disclose my health information to the trustee of my superannuation fund (or their appointed administrator) to enable them to comply with their legal obligations.

I agree that any information or documents sought could also be used to investigate any non-disclosure or misrepresentation by me, such as at the time of applying for cover or to increase the amount or scope of my cover.

I agree that a photostat copy of this declaration and authority shall be considered as valid as the original.

I understand that if I do not agree to this, Zurich will not be able to further assess my claim.

Name (please print)

Signature

✗ Date (dd/mm/yyyy) / /

Privacy declaration:

I consent to the collection, use, storage and disclosure of my personal information (including health and other sensitive information) as described in Zurich's Privacy Policy, available at zurich.com.au/important-information/privacy

I acknowledge that I have been provided with Zurich's Privacy Statement, which provides information about how Zurich collects, uses and discloses my personal information (including health and other sensitive information), and I understand further information is available in the Zurich Privacy Policy available at zurich.com.au/important-information/privacy I understand that Zurich will not be able to process my claim or administer this policy without this consent.

Zurich values your privacy and information security. Please be aware that email is not a secure method of communication and there are risks with using email to send information. If you wish to email your claim form to us, we encourage you to consider encrypting it. For more information please contact us.

Signature

✗ Date (dd/mm/yyyy) / /

Additional information/comments

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 559998_OPLM2472a/0822

ZURICH®