Group Risk Insurance
Group Salary Continuance
Attending Doctor's Statement

Initial Claim Form

This form is to be completed by your attending doctor.

NB: If there is a charge for completion of this form, it is the responsibility of the Insured. Zurich Australia Limited will not be responsible for payment of the completion of the form.

Policy number ____________ Policy name ____________

1 Insured's details

1. Surname ____________ Given name(s) ____________

   Date of birth / / Gender ◯ Male ◯ Female

2. Are you the insured's usual doctor? Yes ◯ No ◯
3. (a) Are you the treating GP/specialist? Yes ◯ No ◯

   If specialist, what is your speciality?

   (b) If the insured was referred to you, please provide the date of referral and by whom.

   Date / / Doctor's name

   Doctor's address

4. Date the insured was first **ever** seen by you? / /
5. Date the insured was first seen for the current condition? / /
6. Is the condition a: ◯ Sickness ◯ Injury
7. If sickness, when did symptoms first appear? / /
8. If injury, when did the incident occur? / /
9. Has the insured ever had the same or similar condition? Yes ◯ No ◯

   If 'Yes', please provide the date and details of previous condition / /

10. (a) What is the date of diagnosis and current diagnosis for the insured? / /

    (b) What tests, examinations or studies have been conducted to confirm your diagnosis.

Test/Examination/Study	Date	Result
	/ /	
	/ /	
	/ /	
	/ /	

IMPORTANT – Please attach copies of all tests/investigations

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1 Insured's details (continued)

11. Advise the symptoms and objective signs causing the disability.

12. Are there any other sicknesses or injuries affecting this insured's ability to work or their working hours? Yes ◯ No ◯

If 'Yes', please describe

13. Describe all treatment being provided including all medication and dosages administered.

Date	Treatment/Medication	Frequency of dosage	Result/Response
/ /			
/ /			
/ /			
/ /			

14. Has the insured ever refused treatment for surgery or medication? Yes ◯ No ◯ If 'Yes', why?

15. Provide the date you certified the insured unable to work

Totally / / Partially / /

16. To the best of your knowledge, when did the insured cease work? / /

17. Does the insured's condition currently prevent them from performing the usual duties of their occupation in a

Total capacity? Yes ◯ No ◯ If 'Yes', please go to question 18

Partial capacity? Yes ◯ No ◯ If 'Yes', please answer below

What duties can the insured perform?

Occupational duty	Can undertake	Cannot undertake	Reasons/Restriction/Modification
	◯	◯	
	◯	◯	
	◯	◯	
	◯	◯	

18. If the insured is unable to perform the duties of their usual occupation, when will the insured be able to return to work?

Full-time / / Part-time / /

19. Has the insured been hospitalised? Yes ◯ No ◯

Name of hospital

Procedure/Treatment

Date admitted / / Date discharged / /

Name of doctor

20. Have you referred the insured to another doctor?

No ◯ go to question 21 Yes ◯ If 'Yes', provide the following details

Doctor's name

Speciality

Address

Reason for referral

1 Insured's details (continued)

21. Describe your future management of this condition. Is a change in treatment contemplated?

22. Have you commenced rehabilitation or return to work program with the insured? Yes ◯ No ◯
    If 'Yes', please describe. If 'No', please give reasons.

23. Are you providing certificates/reports for another insurer/third party in relation to the insured? Yes ◯ No ◯
    If 'Yes', please provide full details.
    Name of organisation
    Reference
    Address

IMPORTANT – Please attach any of your reports provided to a another insurer/third party

24. Any additional comments/remarks that may assist us in assessing this claim

Please provide your details below and we thank you for completing the medical section of the form.

2 Declaration

I hereby declare that the above statements are true and correct.

Signature of doctor	Date
✗	/ /

Name

Address

Qualifications Specialist Yes ◯ No ◯

Telephone number Email

Privacy

Zurich is bound by the Privacy Act 1988 (Cth). In completing the forms or questions herein you will be providing us with personal and, perhaps, sensitive information. The collection and management of this information is governed by the Privacy Act 1988. For a more detailed explanation of Zurich's Privacy Policy please visit our website at www.zurich.com.au or contact the Zurich Privacy Officer on 132 687 or email us at privacy.officer@zurich.com.au

Please send your completed form to:

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North Sydney NSW 2059

or Email: grouprisk.claims@zurich.com.au
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