Group Risk Insurance
Group Salary Continuance
Member's Statement

ZURICH

Initial Claim Form

All forms must be completed. The life insured is to complete the Initial Claim Form, the policy owner is to complete the Employer's Statement and the treating doctor is to complete the Attending Doctor's Statement. Incomplete claim forms may delay assessment of the claim. If there is insufficient space to adequately answer any question, please attach additional pages.

Please note, the insurer has not admitted any liability to pay the claim by issuing this claim form.

Policy name

Policy number

Member number

1 Claimant details

◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other – please specify

Surname Given name(s)

Date of birth / /

Home phone number Business phone number

Mobile number Email address

Height cm Weight kg Occupation

Residential address Postcode

2 Current work details

1. Annual salary at time of claim? Annual Income $
2. Please advise your occupation immediately prior to your sickness/injury
3. Please advise how long have you worked in your current occupation Years Months
4. What basis is your employment? ◯ Full time ◯ Part time ◯ Casual
5. How many hours per week did you normally work prior to your injury/sickness? hours
6. Please indicate your current employment status

   ◯ Disability leave ◯ Still employed ◯ Terminated ◯ Redundant ◯ Resigned ◯ Retired

   ◯ Other – please specify
7. Were you paid sick leave?

   No ◯ go to question 8 Yes ◯ If 'Yes', please provide details

   Period of sick leave – From / / To / /

   Total gross amount paid $
8. Provide details of your employer at the Date of Disability

   Employer name

   Address Postcode

   Telephone number

   Contact name

ZU11306 - V2 02/14 - SROE-008517-2014

3 Claims details

9. Advise the name of the sickness or injury which caused you to cease all work

10. If a **sickness**, when did you first notice symptoms? Date / /

Description of onset of symptoms

11. If you were injured, please provide details Date / /

How did the injury/accident occur?

12. What was the date you last attended work both in a full time and part time capacity?

Full time / / Part time / /

13. When did you cease all work? Date / /

14. Advise the date when you expect to return to work in either a full time or part time capacity?

Full time / / Part time / /

15. (a) Please advise of your current symptoms and how do these affect your ability to work?

(b) Please specify which duties you can/cannot perform

Occupational duty	Can undertake	Cannot undertake	Reasons

4 Medical details

16. (a) Advise the date and result of your first consultation for the current condition Date / /

(b) Provide the name, address and speciailty of who you consulted

Name

Address

Speciality

17. List all treatment received (including physiotherapy, acupuncture, etc) for this condition or related conditions

Name of condition	Name of doctor and speciality	Date/frequency of treatment	Type of treatment	Results/prognosis Duration of condition, time off work

You may wish to attach a separate sheet if there is insufficient space

4 Medical details (continued)

18. (a) Were you admitted to hospital for this condition?

No ◯ go to question 19 Yes ◯ If 'Yes', please provide details below

Date admitted / / Date discharged / /

Name of hospital

Name of doctor

(b) Was an operation performed?

No ◯ go to question 19 Yes ◯ If 'Yes', please provide details below

Nature of operation

Date performed / / Name of surgeon

19. Have you discussed a return to work plan with your doctor?

Yes ◯ If 'Yes', please provide details No ◯ If 'No', please provide reasons

20. Has rehabilitation been attempted?

Yes ◯ If 'Yes', please provide details No ◯ If 'No', please provide reasons

21. Have you consulted any doctor including psychiatrist, or sought any para-medical treatment from a physiotherapist, chiropractor or any person practising alternative medicine for any OTHER condition in the last 5 years?

No ◯ go to question 22 Yes ◯ If 'Yes', please provide details below

Type of treatment	Name of medical attendant	Date/frequency of treatment

5 Occupation

22. Describe your occupation in the following categories

◯ Heavy manual ◯ Light manual ◯ Clerical ◯ Manager/supervisory

◯ Other – please specify

23. If you perform supervisory duties, how many people do you supervise?

24. If you do manual work, please advise the percentage of your week spent doing **manual** work

◯ 0-10% ◯ 11-20% ◯ 21-30% ◯ 31-40% ◯ 41-50% ◯ 51% or more

25. Advise all duties you actually perform, the number of hours you perform **each duty per week** and any machines, equipment or tools that you use to perform these duties

List each duty performed	Machines, equipment or tools used to perform this duty	Total hours of this duty performed per week
	Total number of hours worked per week	

5 Occupation (continued)

26. Do you have trade/tertiary/professional qualifications?

No ◯ go to question 27 Yes ◯ If 'Yes', please provide details

27. Have you previously worked in any other occupations or for other employers?

No ◯ go to question 28 Yes ◯ If 'Yes', **Either complete the table below or submit a copy of your resume**

Period employed from	Period employed to	Employer/Business name	Occupation	Duties
/ /	/ /			
/ /	/ /			
/ /	/ /			
/ /	/ /			
/ /	/ /			

6 Other details

28. (a) Have you lodged a workers' compensation claim?

No ◯ go to part (b) Yes ◯ If 'Yes', please provide information

Date lodged / /

Insurer's name

Insurer's address

Claim number Case manager

(b) Do you intend lodging a workers' compensation claim? Yes ◯ No ◯

If 'Yes', when? / /

If 'No', please explain the reason(s) for your response

(c) Has your workers' compensation claim been denied?

No ◯ go to question 28 (d) Yes ◯ If 'Yes', please provide reason

(d) Has your workers' compensation claim been accepted?

No ◯ go to question 29 Yes ◯ If 'Yes', please provide details

Date accepted / /

Monthly gross benefit $

If settled, settlement amount $

29. Have you ever made another claim for this sickness/injury?

No ◯ go to DECLARATION Yes ◯ If 'Yes', please provide information

◯ Centrelink ◯ Dept of Veterans' Affairs ◯ Third Party Insurance ◯ Other Life Insurer ◯ Superannuation Fund

◯ Public Liability ◯ Transport Accident ◯ Other – please specify

Monthly gross benefit $ Branch/Insurer

Date lodged / / Claim / ID / Reference number

Address

Contact number

If any part of this form is not complete it will be returned to you for completion.

Any changes or amendments to this form must be initialled by the signatory.

7 Authorities and Declarations

I hereby declare that the information in this Claim Form is true, correct and complete. I understand and agree that if I make any false or fraudulent statements, or fail to advise of any relevant information regarding my claim, then my claim may be refused.

I also understand that I can be prosecuted if I make a fraudulent statement.

Name

Signature ✗ Date / /

Medical authority

I hereby authorise any dentist, hospital, doctor or other person who has attended me, to release to Zurich Australia Limited ABN 92 000 010 095 AFSL 232510, or its representatives, all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment and copies of all hospital or medical records. I agree that a photocopy (or similar copy) of this authorisation shall be as effective and valid as the original.

Name

Signature ✗ Date / /

Information authority

I hereby authorise any insurer, accountant, my employer, service providers, institution or police service to release to Zurich Australia Limited or its representatives, all information which Zurich Australia Limited requests for the purpose of assessing or investigating my claim. I agree that a photocopy (or similar copy) of this authorisation shall be as effective and valid as the original.

Name

Signature ✗ Date / /

Privacy – Use and Disclosure of Personal Information

Zurich is bound by the Privacy Act 1988 (Cth). Before providing us with any Personal or Sensitive Information ('Information'), you should know the following information.

We collect, use, process and store Personal Information and, in some cases, Sensitive Information about you in order to comply with our legal obligations, to assess your application for insurance cover, to administer the insurance cover provided, to enhance customer service or products and to manage claims ('purposes'). If you do not agree to provide us with the Information, we may not be able to process your application, administer your cover or assess your claims.

By providing us or your intermediary with your Information, you consent to our use of this Information which includes us disclosing your Information where relevant for the purposes, to the Policy Owner, your intermediary, affiliates of the Zurich Insurance Group Ltd, other insurers and reinsurers, our service providers, our business partners or as required by law within Australia or overseas. Zurich may obtain Information about you from government offices and third parties to assess a claim. We may use Personal Information (but not Sensitive Information) collected about you to notify you of other products and services we offer. If you do not want your Personal Information to be used in this way, please contact us.

For further information about Zurich's Privacy Policy, a list of service providers and business partners that we may disclose your Information to, a list of countries in which recipients of your Information are likely to be located, details of how you can access or correct the Information we hold about you or make a complaint, please refer to the Privacy link on our homepage – www.zurich.com.au, contact us by telephone on 132 687 or email us at privacy.officer@zurich.com.au

Please send your completed form to:

Zurich Australia Limited
Group Risk Insurance
Locked Bag 994
North Sydney NSW 2059

or Email: grouprisk.claims@zurich.com.au
For more information, please contact Group Risk Claims:
Phone: 131 551
Fax: 02 9995 3732