Group Risk Insurance
Group Salary Continuance
Partial Disability

ZURICH

Progress Report Form

Pages 1-4 are to be completed by you and pages 5-7 are to be completed by your treating doctor.

Instructions for completion of this form

- Please ensure that you and your doctor answer all questions.
- If this form is not fully completed assessment of your claim will be delayed and your benefits may not be processed.
- You are required to complete pages 1 – 4 of this form prior to consultation with your doctor.
- There are different requirements for people who are self employed and for people who are employees. Please ensure that you complete the part of the form which is relevant to your employment status.
- **In completing this form you must tell us about ALL the work you do, whether paid or unpaid, including voluntary work.**
- Throughout this form, the term 'work' refers to your own or any other occupation, either paid or unpaid.
- Please note 'as before' or 'same as before' are not acceptable entries and will delay the assessment of the claim and/or jeopardise payment of benefits.
- **If there is a fee associated with completion of this form by your doctor, payment is your responsibility.**
- Should you require assistance in completing this form, please call us on 131 551 during business hours.
- If there is not enough space for an answer please attach a separate page.

Policy number

Claim number

1 Claimant details

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

Surname Given name(s)

Date of birth / / Occupation

Home phone number Business phone number

Mobile number Email address

Residential address (we do no accept PO Boxes)

Address Postcode

1. (a) Name of your current injury or sickness

Injury Sickness

(b) Provide details of your current symptoms

Are you SELF EMPLOYED?

No ◯ go to question 3 Yes ◯ go to question 2

ZU11309 - V2 02/14 - SROE-008506-2014

1 Claimant details (continued)

2. (a) What is the gross income earned by your business (since your return to work) due to your personal exertion or activities?

$

(b) Please advise below your share of business expenses (since your return to work) that were necessarily incurred in generating the income for your business. For example, accounting fees, advertising, electricity, gas, rates, rent, etc. Please attach a separate sheet if necessary. (Note that verification of these expenses may be required)

Expenses type	Amount
	$
	$
	$
	$
	$
	$

(c) How many employees are there in your business?

Full-time Part-time Contractors/Casuals

(d) Have you employed anyone to replace you?

No ◯ go to question 2 (e) Yes ◯ If 'Yes', advise on what basis this has occurred

(e) Has your business ceased trading since you became disabled?

Yes ◯ When? / / Go to question 5

No ◯ If 'No', provide details and then to to question 5

If you are an EMPLOYEE then please complete the questions below

3. Details of your employer

Name

Address Postcode

Business phone Number Contact name

4. Total gross income for this claim period $

Please attach a copy of your payslip or confirmation from your employer for this amount

5. Advise details of all the work you have completed, paid or unpaid, during this claim period

Date	Hours worked	Duties performed
/ /		
/ /		
/ /		
/ /		
/ /		
/ /		
Please attach additional information should the space provided above be insufficient		

1 Claimant details (continued)

6. Advise the duties you are unable to perform, including reasons

Duties	Reason

7. How many hours are you working on average per week? Hours per week

8. Do you anticipate increasing your hours?

No ◯ go to question 9 Yes ◯ If 'Yes', please state

Date to commence / / Increase of hours

9. When do you anticipate returning to full-time work? / /

If you do not anticipate returning to full-time work, provide reasons why

10. Advise details of the treatment you are currently undertaking/receiving

Name of doctor/medical attendant	Date of consultation	Type of treatment including medication	Frequency of treatment
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		

11. Since your last form, has your condition improved?

Yes ◯ If 'Yes', describe how your condition has improved

No ◯ If 'No', please provide reasons below

12. (a) Are you receiving benefits from a third party (e.g. Workers' Compensation, Centrelink, Transport Accident/CTP, Department of Veterans' Affairs, court settlement)?

No ◯ go to question (b) Yes ◯ If 'Yes', please provide details

Gross monthly benefit amount $ Type of benefit

Frequency of payment ◯ Weekly ◯ Fortnightly ◯ Monthly

Claim/Reference number Contact name

(b) Please provide details below if you are in receipt of any other income whatsoever:

Payment source Gross amount per week $

Please attach a copy of the payment advice or proof of income for the above

1 Claimant details (continued)

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

/ /

Declaration

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 the insurer, Zurich of any relevant information regarding my claim, the insurer may refuse to pay and cancel my claim. I understand that I can be prosecuted if I make false statements.

Name

Signature

✗

Date

/ /

2 To be completed by your treating doctor

Life Insured Claim number

Period claimed / / to / /

Progress Report Form – GSC – Partial Disability

Instructions for completion of this form

- Please complete this form after the claimant has completed their section.
- Please ensure that you answer all questions.
- Please note 'as before' or 'same as before' are not acceptable entries and will delay the assessment of the claim and/or jeopardise payment of benefits.
- In completing this form you must tell us about ALL the work the claimant does, whether paid or unpaid, including voluntary work.
- **If there is a charge in association with completing this form, payment is the responsibility of the claimant.**
- We encourage an objective assessment of the claimant's condition.
- Should you require assistance in completing this form please call us on 131 551 during business hours.
- If there is not enough space for an answer please attach a separate page.

1. Claimant's full name

2. Current diagnosis

3. (a) When did you last **examine** the claimant? Advise of your findings on examination, including symptoms and objective signs causing disability

Date / /

(b) Has the claimant's condition improved, deteriorated or remained the same?

4. Advise of the treatment (including medication) being provided and the response to this treatment

Type of treatment including medication	Frequency of treatment	Result/response

5. Advise the date/s and result/s of all tests or scans performed since the last submitted form. **Attach copies of these results/tests.**

Date	Test/Scan type	Result
/ /		
/ /		
/ /		
/ /		

6. Have you referred the claimant to any specialist/s since the last submitted form?

No ◯ go to question 7 Yes ◯ If 'Yes', please provide details

Name of doctor and speciality	Address	Date referred
		/ /
		/ /
		/ /
		/ /

2 To be completed by your treating doctor (continued)

7. Has the claimant been hospitalised since the last form?

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

Date admitted	Date discharged	Hospital	Procedure
/ /	/ /		
/ /	/ /		
/ /	/ /		
/ /	/ /		

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

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9. Advise of the planned future treatment

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10. List the daily living activities of the claimant and specify those that they can and cannot perform

Activity	Can undertake	Cannot undertake	Reasons
	◯	◯	
	◯	◯	
	◯	◯	
	◯	◯	

11. List all duties of the claimant's occupation and specify those that they can and cannot currently perform

Occupational duty	Can undertake	Cannot undertake	Reasons
	◯	◯	
	◯	◯	
	◯	◯	
	◯	◯	

12. Do you recommend an increase in the claimant's current hours worked?

Yes ◯ If 'Yes', please provide reasons including the level of increase

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No ◯ If 'No', provide your reasons

.....

.....

13. Can the claimant return to full-time employment?

Yes ◯ If 'Yes', when this is expected to occur / /

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No ◯ If 'No', provide your reasons

.....

.....

14. Advise any complications or other factors which may prolong the claimant's condition

.....

.....

15. Provide any additional comments/remarks

.....

.....

3 Declaration

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

Signature	Date
✗	/ /

Name Phone number

Address Postcode

Qualifications

Treating specialist Yes ◯ No ◯ Speciality

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:

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