Group Risk Insurance Group Salary Continuance Total Disability

Progress Report Form

Pages 1-3 are to be completed by you and pages 4-6 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 – 3 of this form prior to consultation with your doctor.
- **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

2. Provide details of all treatment since the last form, including medications/dosages/frequency

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

ZU11310 - V2 02/14 - SROE-008506-2014

1 Claimant details (continued)

3. Has your condition improved since your last submitted form?

No ◯ go to question 4 Yes ◯ If 'Yes', please provide details

4. Were you referred to any specialist/s

No ◯ go to question 5 Yes ◯ If 'Yes', please provide name/s and address/es and any pending appointment/s you may have

Name of medical attendant	Address	Date of consultation
		/ /
		/ /
		/ /
		/ /

5. Have you been admitted to hospital since your last submitted form?

No ◯ go to question 6 Yes ◯ If 'Yes', please provide details

6. (a) Have you returned to work?

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

Date commenced / / Occupation Hours per week

Name of employer

Address of employer

Gross income earned $

Please attach a copy of your payslip or confirmation letter from your employer for the period worked and amount paid.

(b) Please advise when you expect to return to work

◯ Part-time / / ◯ Full-time / /

7. Has your return to work been delayed?

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

8. List all your daily activities and the time spent performing these activities. (This includes work which is voluntary or otherwise, and any domestic and social activities you undertake)

9. List below the duties of your occupation that you are able and unable to perform *(Please list all duties of your occupation. Tick which column is applicable for each duty)*

Duties	Able to perform	Unable to perform
	◯	◯
	◯	◯
	◯	◯
	◯	◯
	◯	◯

1 Claimant details (continued)

10. Are you undertaking any further study or training courses?

No ◯ go to question 11 Yes ◯ If 'Yes', please provide details

Institution Date commenced / /

Course name Duration Frequency of attendance

11. (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

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 or its representatives, all information which Zurich 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 – Total 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 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 9 Yes ◯ If 'Yes', please provide details

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

8. Have the claimant refused treatment options? Yes ◯ No ◯ If 'Yes', why?

9. Advise the planned future treatment

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 the claimant's occupation and specify those that they can and cannot perform

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

12. Has the claimant returned to work?

Yes ◯ If 'Yes', provide the date and the capacity in which they returned to work including any restrictions

Date / /

No ◯ If 'No',

(a) Provide the dates as to when you expect the claimant to return to work

◯ Part-time / / ◯ Full-time / /

(b) Would the claimant benefit from an occupational rehabilitation program? Yes ◯ No ◯

Provide reasons for your response

(c) Do you feel that the claimant is motivated (regardless of condition) to return to work? Yes ◯ No ◯

Provide details as to what brings you to this conclusion

2 To be completed by your treating doctor (continued)

13. Advise of any complications or any other factors that may prolong the claimant's condition

14. Have you provided any information to another insurer in respect of the claimant for this or related condition?

No ◯ go to question 15 Yes ◯ If 'Yes', provide the name of the insurer and the reason/s for provision of information

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