

Group Risk Insurance Employer's Statement Terminal Illness Benefit



Initial Claim Form

This form is to be completed by your employer

Policy number

Policy name

1 Employee details

Name of employee				Occupation			
Date joined company	/	/		Date joined plan	/	/	
Plan name							
Policy number				Member number			
Basis of employment	<input type="radio"/> full-time	<input type="radio"/> part-time	<input type="radio"/> casual	<input type="radio"/> other			
If other is ticked, please give details							
Number of hours worked				hours per day			
Total salary last 12 months	\$	pa		\$	base		
Commission/Bonus	\$	pa		\$	super		
Other, please specify	\$	pa					

2 Declaration

I hereby certify the information stated above is correct to the best of my knowledge.

Signature of authorised representative	Date
X	/ /

Name and title

Name of company

Address

Telephone number

Facsimile number

Email



Privacy

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Please send your completed form to:

**Zurich Australia Limited
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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