

# Group Risk Insurance Attending Doctor's Statement General Practitioner Total and Permanent Disablement



This form is to be completed by your 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

Height cm Weight kg

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

Postcode

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**

**1 Insured's details (continued)**

11. What are the symptoms and objective signs causing the disability

.....

.....

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

Date	Treatment/Medication	Frequency	Result/Response
/ /			
/ /			
/ /			
/ /			

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

.....

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

Totally / / Partially / /

15. What is the insured's occupation?

.....

16. To the best of your knowledge, when did the insured cease all 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 16

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

Duties	Restriction/Modification

18 (a) 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 / /  Never

(b) Please advise whether, in your opinion, you believe the insured could return to work in any other occupation? Yes  No   
If 'Yes', please advise what occupations you believe the insured could undertake, given their condition.

.....

.....

19. Please advise whether you consider the insured's limitations to be permanent and untreatable. If so, why?

.....

.....

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

If 'Yes', please describe

.....

.....

21. Are there any lifestyle factors that led to or have impacted on the condition? Yes  No

If 'No', go to question 22  
If 'Yes', please describe

.....

.....

22. Have you commenced rehabilitation or a return to work program with the insured? Yes  No

If 'Yes', please describe. If 'No', please give reasons

.....

.....

## 1 Insured's details (continued)

23. Have you referred the insured to any specialist/s?

No  go to question 24

Yes  If 'Yes', please provide details

Name of doctor and speciality	Address	Referral date
		/ /
		/ /
		/ /

24. Has the insured been hospitalised?

No  go to question 25

Yes  If 'Yes', please provide details

Date admitted	Date discharges	Hospital	Procedure
/ /	/ /		
/ /	/ /		
/ /	/ /		

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

.....  
.....

26. Are you providing certificates/reports for another insurer/third party in relation to the insured? Yes  No  If 'Yes', provide full details

Name of organisation

Reference

Contact name

Address

Postcode

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

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

.....  
.....  
**Please provide your details below and we thank you for completing this form.**

## 2 Declaration

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

Signature of doctor <b>X</b>	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](http://www.zurich.com.au) or contact the Zurich Privacy Officer on 132 687 or email us at [privacy.officer@zurich.com.au](mailto: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](mailto:grouprisk.claims@zurich.com.au)

For more information, please contact Group Risk Claims:

Phone: 131 551

Fax: 02 9995 3732