Group Risk Insurance
Attending Doctor's Statement
Specialist
Total and Permanent Disablement

ZURICH

This form is to be completed by your specialist.

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. Please provide the date of referral and by whom Date / /

Doctor's name

Doctor's address Postcode

3. Date the insured was first ever seen by you? Date / /

4. Date the insured was first seen for the current condition? Date / /

5. Is the condition a: ◯ Sickness ◯ Injury

6. If sickness, when did symptoms first appear? Date / /

7. If injury, when did the incident occur? Date / /

8. Has the insured ever had the same or similar condition? Yes ◯ No ◯

If 'Yes', please provide the date and details of previous condition Date / /

9. (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

ZU11315 - V2 02/14 - SROE-008506-2014

1 Insured's details (continued)

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

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

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

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

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

Totally / / Partially / /

14. To the best of your knowledge, when did the insured cease work? / /

15. What is the Insured's occupation?

16. 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 17

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

Duties	Restriction/Modification

17 (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.

18. Please advise whether you consider the insured's limitations to be permanent and untreatable. Yes ◯ No ◯
If 'Yes', please give reasons for your answer

19. Are there any other sicknesses or injuries affecting the insured's ability to work or their working hours? Yes ◯ No ◯
If 'Yes', please describe

20. Are there any lifestyle factors that led to or have impacted on the condition? Yes ◯ No ◯
If 'Yes', please provide details

21. 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)

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

No ◯ go to question 23 Yes ◯ If 'Yes', please provide details

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

23. Has the insured been hospitalised?

No ◯ go to question 25 Yes ◯ If 'Yes', please provide details

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

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

25. 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.

26. 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	Date
✗	/ /

Name

Address

Qualifications

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 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