Group Risk Insurance
Member's Statement
Total and Permanent Disablement

All forms must be completed. The life insured is to complete the Initial Claim Form, the employer is to complete the Employer's Statement and two treating doctor's (specialist and general practitioner) are to complete the Attending Doctor's Statement. Incomplete claim forms may delay assessment of the claim. If there is insufficient space to adequately answer any question, please attach additional pages.

Please note, the insurer has not admitted any liability to pay the claim by issuing this claim form.

Policy name

Policy number

Member number

1 Claimant details

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

Surname

Given name(s) Date of birth / /

Home phone number Business phone number

Mobile number Email address

Height cm Weight kg Occupation

Residential address Postcode

Business address (if self-employed) Postcode

Business phone number

2 Claim details

1. Advise the name of the sickness or injury which caused you to cease all work

2. If a **sickness**, when did you first notice symptoms? Date / /

   Description of onset of symptoms

3. If you were **injured**, please provide details Date / /

   How did the injury/accident occur?

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2 Claim details (continued)

4. What was the date you last attended work both in a full time and part time capacity?

Full-time / / Part-time / /

5. When did you cease all work? Date / /

6. Please provide details below as to which work duties you are unable to perform as a result of your condition? Please include activities such as standing, sitting, kneeling, bending, climbing ladders or steps, lifting, carrying, telephone work, computer work and meetings.

List each work duty and activity you are experiencing difficulty performing	List the symptom(s) which prevent(s) or limits you in performing this duty	Extent of inability to perform each duty Slightly	Moderately	Fully
		◯	◯	◯
		◯	◯	◯
		◯	◯	◯
		◯	◯	◯
		◯	◯	◯
		◯	◯	◯
		◯	◯	◯
		◯	◯	◯

3 Medical details

7. (a) Provide the name, address and speciality of the doctor who you first consulted

Name Speciality

Address Postcode

(b) Please advise of the date you first saw the doctor and the treatment provided / /

8. Please provide full details of all other doctors and all other therapists (eg, chiropractors, physiotherapists, psychologists etc) you have consulted in relation to the condition, including the dates, the treatment received and the medication prescribed.

List each consultation separately

Name of doctor or attendant, speciality and contact phone number	What treatment was provided?	What medication was prescribed and are you still using it?
Date of consultation / /		
Name		
Speciality		
Phone number		Still using? ◯ Yes ◯ No
Date of consultation / /		
Name		
Speciality		
Phone number		Still using? ◯ Yes ◯ No
Date of consultation / /		
Name		
Speciality		
Phone number		Still using? ◯ Yes ◯ No

You may wish to attach a separate sheet if there is insufficient space

3 Medical details (continued)

9. (a) Were you admitted to hospital for this condition?

No ◯ go to question 10 Yes ◯ If 'Yes', please provide details below

Date admitted / / Date discharged / /

Name of hospital

Treatment

(b) Was an operation performed?

No ◯ go to question 10 Yes ◯ If 'Yes', please provide details below

Nature of operation

Date performed / / Name of surgeon

4 Employment

10. What was your occupation immediately prior to your sickness/injury?

11. Describe your occupation in the following categories

◯ Professional ◯ White Collar ◯ Light Blue Collar

◯ Heavy Blue Collar (skilled) ◯ Heavy Blue Collar (unskilled) ◯ Other – please specify

12. How long have you worked in your current occupation? years months

13. What basis was your employment? ◯ Full-time ◯ Part-time ◯ Casual

14. How many hours per week did you normally work prior to your injury/sickness? hours

15. Annual salary prior to sickness/injury $

16. Please indicate your current employment status

◯ Disability leave ◯ Still employed ◯ Terminated ◯ Redundant

◯ Resigned ◯ Retired ◯ Other – please specify

17. Please list all duties you actually performed, the number of hours you performed each duty per week and any machines, equipment or tools that you use to perform these duties. Please include activities such as standing, sitting, kneeling, bending, climbing ladders or steps, lifting, carrying, telephone work, computer work and meetings.

List each duty performed	**Machines, equipment or tools used to perform this duty**	**Total hours of this duty performed per week**
	Total number of hours worked per week	

18. If you perform supervisory duties, how many people do you supervise?

19. Have you made any attempts to return to work with your current employer?

No ◯ go to question 20 Yes ◯ If 'Yes', please provide details below

Period employed from	**Period employed to**	**Duties performed**
/ /	/ /	
/ /	/ /	
/ /	/ /	

4 Employment (continued)

20. Have you sought or worked in alternative employment (including voluntary work) since your injury/sickness?

No ◯ go to question 21 Yes ◯ If 'Yes', please provide details below

Period employed from	Period employed to	Organisation name and address	Duties performed
/ /	/ /		
/ /	/ /		
/ /	/ /		

21. Have you undergone a rehabilitation program?

Yes ◯ If 'Yes', please provide details No ◯ If 'No', please provide reasons

22. (a) Do you have trade/tertiary/professional qualifications?

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

Name of institute	Year completed	Qualifications gained

(b) What is your highest level of schooling? (What year did you complete your schooling)?

23. Have you previously worked in any other occupations or for other employers?

No ◯ go to question 24 Yes ◯ If 'Yes', either complete the table below or submit a copy of your resume

Period employed from	Period employed to	Employer/Business name	Occupation	Duties
/ /	/ /			
/ /	/ /			
/ /	/ /			
/ /	/ /			
/ /	/ /			

24. Provide details of your employer at the date of disability

Employer name

Address Postcode

Telephone number Contact name

If SELF EMPLOYED, please answer the following questions. Otherwise, please go to Section 5 Other details.

25. Please provide details below of the names of all businesses/entities/companies where you have had ownership/involvement

26. Has your business ceased trading since your became disabled? Yes ◯ No ◯ If 'Yes', please provide details

27. Have your or any of your family members been involved in the continued running of the business?

No ◯ go to question 28 Yes ◯ If 'Yes', please provide details

5 Other details

28. (a) Have you lodged a workers' compensation claim?

No ◯ go to Part (b)   Yes ◯ If 'Yes', please provide information

Date lodged / /

Insurer's name

Insurer's address   Postcode

Claim number   Case manager

(b) Do you intend lodging a workers' compensation claim?

◯ Yes, When? / /

◯ No, please explain the reasons for your response

(c) Has your workers' compensation claim been denied?

No ◯ go to question 28 (d)   Yes ◯ If 'Yes', please provide reasons

(d) Has your workers' compensation claim been accepted?

No ◯ go to question 29   Yes ◯ If 'Yes', please provide details

Date accepted / /

Monthly gross benefit $

If settled, settlement amount $

29. Have you ever made another claim for this sickness/injury?

No ◯ go to DECLARATION   Yes ◯ If 'Yes', please provide information

◯ Centrelink ◯ Dept of Veterans' Affairs ◯ Third Party Insurance ◯ Other Life Insurer ◯ Superannuation Fund

◯ Public Liability ◯ Transport Accident ◯ Other – please specify

Monthly gross benefit $ Branch/Insurer

Date lodged / /   Claim / ID / Reference number

Address   Postcode

Contact number

If any part of this form is not complete it will be returned to you for completion.

Any changes or amendments to this form must be initialled by the signatory.

6 Authorities and Declarations

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, employer, 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 / /

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Name

Signature ✗ Date / /

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
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