ZURICH

Total and Permanent Disablement Claim Member Statement

Please note:

- There are information security risks associated with using email to send information.
- Print in black or blue ink.
- Please ensure questions are answered in full where possible. Incomplete and unanswered questions may result in your claim being delayed and could result in this form being returned to you for completion.
- Please attach a separate page if you need more space for an answer.

Please attach the following items with your completed form:

- Certified copy of your current driver's licence or passport
- X-ray and other radiology reports, pathology and other test results
- Copies of medical reports in respect of the claimed condition
- Any other information that will assist your claim.

Name of Superannuation Fund/Employer | Policy Number

1. Member details

Title ◯ Mr ◯ Mrs ◯ Miss ◯ Ms Other

Surname

Given name(s) | Member number

Maiden name and/or alias | Date of birth (dd/mm/yyyy) / /

Street no. and name

Suburb/Town | State | Postcode

Phone number | Home | Mobile

Email

Do you need an interpreter? ◯ Yes ◯ No | If **yes**, in what language?

Date last actively at work (dd/mm/yyyy) / / | Do you permanently reside in Australia? ◯ Yes ◯ No

Name of employer

Employer contact details

2. Reason for ceasing work

2.1 What is the reason for ceasing work?

◯ Illness – see Q3 ◯ Injury – see Q4 ◯ Redundancy ◯ Resignation ◯ Termination

2.2 Please provide details.

3. Illness

Complete only if you suffered an illness.

3.1 What is the nature of your illness?

3.2 When were you first aware of it? (dd/mm/yyyy) / /

When was the condition first diagnosed? (dd/mm/yyyy) / /

3.3 Have you previously suffered from the same or related illness? ◯ Yes ◯ No If **yes**, please provide details

4. Injury

Complete only if you have suffered an injury.

4.1 Please describe the nature and extent of your injury.

4.2 When did it occur? (dd/mm/yyyy) / /

4.3 How did the injury occur?

4.4 Please advise the name and contact numbers of any witness and also attach any relevant police/injury reports, etc.

5. Concurrent medical conditions

5.1 Do you suffer from any other medical conditions? ◯ Yes ◯ No If **yes**, please provide details

6. Work activities

6.1 As a result of your injury/illness have you decreased your work activities? ◯ Yes ◯ No

6.2 When did you reduce your work activities? (dd/mm/yyyy) / /

6.3 Please provide details of how your work activities have reduced, including what changes occurred as a result of your injury/illness?

6.4 Are you currently performing any work activities? ◯ Yes ◯ No

If **yes**, when did you return to work? (dd/mm/yyyy) / /

6.5 If yes, please provide details, including employer, occupation, duties and hours, capacity and details of any rehabilitation.

6.6 If you have not returned to work, do you anticipate returning to work in any capacity? ◯ Yes ◯ No

6.7 If yes, please provide details, including employer, occupation, duties and hours, capacity and details of any rehabilitation.

7. Treatment

7.1 When did you first attend a doctor for your illness or injury? (dd/mm/yyyy) / /

7.2 What is the name and contact details of that doctor?

Name

Contact details

7.3 Please provide details of all treatment received to date and outline any proposed treatment, including tests and the results.

7.4 In the event that you have declined or deferred any treatment, please detail the declined or deferred treatment and your reasons.

7.5 Please complete the table below with the relevant details of your treatment doctors and providers (including specialists, physiotherapist, psychologist, acupuncturist, etc).

Name	Specialty	Contact details	First attended (dd/mm/yyyy)	Last attended (dd/mm/yyyy)
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /

8. Employment

8.1 What was your occupation immediately prior to your injury/illness?

Job title/position

8.2 In what capacity were you employed immediately prior to the onset of your injury/illness?

○ Casual ○ Part time – permanent ○ Full time – permanent ○ Contractor

Date commenced employment with employer (dd/mm/yyyy) / /

Annual salary (gross before tax) $

Usual hours per week (weekly average over 12 months immediately prior to your injury/illness)

8.3 What were the main duties of your occupation prior to the onset of your injury/illness?

8.4 Please indicate the physical demands of your occupation immediately prior to the onset of your injury/illness.

	Never	Sometimes	Often	Always		Never	Sometimes	Often	Always		Never	Sometimes	Often	Always
Walking	○	○	○	○	Climbing	○	○	○	○	Carrying above 23kg	○	○	○	○
Sitting	○	○	○	○	Driving	○	○	○	○	Reaching (over shoulder)	○	○	○	○
Standing	○	○	○	○	Lifting less than 9kg	○	○	○	○	Reaching (below shoulder)	○	○	○	○
Working with computers	○	○	○	○	Lifting 9kg to 23kg	○	○	○	○					
Kneeling	○	○	○	○	Carrying less than 9kg	○	○	○	○					
Bending	○	○	○	○	Carrying 9kg to 23kg	○	○	○	○					

Key:
Sometimes equals 1/3 of time or less
Often equals between 1/3 to 2/3 of time
Always equals more than 2/3 of time

9. Self-employed

9.1 Have you ever been self-employed and/or owned a business or company? ○ Yes ○ No (If **no**, go to Section 10)

If **yes**, what is/was the main type of business performed?

9.2 Do you hold a current or lapsed ABN number? ○ Yes ○ No

If **yes**, please provide your ABN

9.3 When did the business first trade? (dd/mm/yyyy) / /

When did the business last trade (if applicable)? (dd/mm/yyyy) / /

10. Other income / benefits

10.1 Are you entitled to make a claim, or have you ever made a claim for this injury/illness from any of the following sources?

Workers' compensation ○ Yes ○ No
Motor Accident compensation ○ Yes ○ No
Common Law ○ Yes ○ No
Other government benefit(s) ○ Yes ○ No
Centrelink ○ Yes ○ No
Life insurance ○ Yes ○ No
Other insurance or banks ○ Yes ○ No

If **yes** to any of the above, please provide details in the below table.

Amount	Date from (dd/mm/yyyy)	Date to (dd/mm/yyyy)	Ref No	Name and contact details of benefits provider
$	/ /	/ /		
$	/ /	/ /		
$	/ /	/ /		

Medical and Information Authority

I hereby authorise any doctor, hospital, dentist, allied health professional or any other person whom I have consulted or who has attended me, to release to Zurich or its authorised representative, and the trustee of a superannuation fund of which I am a member (if my claim is linked to such a fund), all information with respect to any illness, accident or injury, medical consultation, prescriptions or treatment and copies of all hospital or medical records, reports or notes.

I hereby authorise any employer, insurer or any other income provider, any accountant, lawyer or any other third party to release to Zurich and the trustee of a superannuation fund of which I am a member (if my claim is linked to such a fund), any information or reports that it requires for the assessment of the claim.

I agree that any information or documents sought could also be used to investigate any non-disclosure or misrepresentation by me, such as at the time of applying for cover or to increase the amount or scope of my cover.

Name (please print)

Signature (sign clearly within the box)

✗ Date (dd/mm/yyyy) / /

Declaration

I hereby declare that the information contained in this statement is true, complete and correct in every detail. I acknowledge my responsibility for the completeness and accuracy of the information, whether the answers have been written, entered or provided by me or by any person on my behalf. I understand and agree that if I make any false or fraudulent statements or fail to advise Zurich of any relevant information regarding my claim, Zurich may be unable to assess my claim and may proceed to cancel my claim and/or my cover. I understand that I can be prosecuted if I make any fraudulent statement.

I acknowledge that I have been provided with Zurich's Privacy Statement, which provides information about how Zurich collects, uses and discloses my personal information (including health and other sensitive information), and I understand further information is available in the Privacy Policy which is available at zurich.com.au/important-information/privacy

I consent to the collection, use, storage and disclosure of my personal information (including health and other sensitive information) as described in Zurich's Privacy Policy available at zurich.com.au/important-information/privacy

Zurich values your privacy and information security. Please be aware that email is not a secure method of communication and there are risks with using email to send information. If you wish to email your claim form to us, we encourage you to consider encrypting it. For more information please contact us.

Name (please print)

Signature (sign clearly within the box)

✗ Date (dd/mm/yyyy) / /

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RHEN-018627-2022 569201-1_OPL8554/0822

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