ZURICH

Group Risk Insurance
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.
- Attach a separate page if more space for an answer is required and clearly indicate to which question the additional information relates.

This is a claim for Income Protection Benefits ◯ Total and Permanent Disablement ◯

Name of Superannuation Fund/Employer

Member number

1. Member details

Title ◯ Mr ◯ Mrs ◯ Ms ◯ Miss Other

Surname

First name(s)

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

Street address (compulsory)

Suburb/Town State Postcode

Postal address (optional)

Phone number Home Mobile

Email

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

Are you a citizen or permanent resident of Australia? ◯ Yes ◯ No

2. Employment details

Name of employer

Employer contact details

2.1 What was your most recent occupation prior to the onset of your injury/illness?

Job title/position

2.2 In what capacity were you employed? ◯ Casual ◯ Part-time – permanent ◯ Full-time – permanent ◯ Contractor

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

Annual salary (gross before tax) $ Hourly rate $

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

2.3 Have you worked for any other employers in the 12 months prior to ceasing work?

Name of employer

Employer contact details

Job title/position

Self employment details)

3. Self-employment details

3.1 Are you or have you ever been self-employed and/or owned a business, company or worked for a family business? ◯ Yes ◯ No

If **yes**, what is/was the main type of business performed? (If **no**, go to Section 4)

3.2 Do you hold a current or lapsed ABN? ◯ Yes ◯ No

If **yes**, please provide ABN – – –

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

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

4. Work activities

4.1 What were the main duties of your most recent occupation prior to the onset of your injury/illness?

Percentage of manual work

Percentage of non-manual work

4.2 Please indicate the physical demands of your most recent occupation prior to the onset of your injury/illness.

	Never	Sometimes	Often	Always
Walking	◯	◯	◯	◯
Sitting	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Working with computers	◯	◯	◯	◯
Kneeling	◯	◯	◯	◯
Bending	◯	◯	◯	◯
Climbing	◯	◯	◯	◯
Driving	◯	◯	◯	◯
Reaching (over shoulder)	◯	◯	◯	◯
Reaching (below shoulder)	◯	◯	◯	◯

	Never	Sometimes	Often	Always
Lifting up to 4.5kg	◯	◯	◯	◯
Lifting 4.5kg to 9kg	◯	◯	◯	◯
Lifting 9kg to 20kg	◯	◯	◯	◯
Lifting above 20kg	◯	◯	◯	◯
Carrying up to 4.5kg	◯	◯	◯	◯
Carrying 4.5kg to 9kg	◯	◯	◯	◯
Carrying 9kg to 20kg	◯	◯	◯	◯
Carrying above 20kg	◯	◯	◯	◯

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

4.3 What is the reason for ceasing work? Tick all relevant box(es)

◯ Illness ◯ Injury ◯ Redundancy ◯ Resignation ◯ Termination

Please provide details. If relevant, please include copies of termination/resignation letter and reasons if related to the claim condition.

4.4 What date did you cease all work? (dd/mm/yyyy) / /

4.5 As a result of your injury/illness were your work activities or hours reduced prior to this date? ◯ Yes ◯ No

If **yes**, please provide details of the reduced work activities/hours, including dates commenced and ceased.

4.6 Have you performed any work activities since the date you originally ceased all work? ◯ Yes ◯ No

If **yes**, please provide details of your return to work, including dates, employer, occupation, duties and hours.

Date from (dd/mm/yyyy)	**Date to** (dd/mm/yyyy)	**Employer**	**Occupation/Duties**	**Hours per week**
/ /	/ /			
/ /	/ /			
/ /	/ /			

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

If **yes**, please provide expected starting date.

Full-time (dd/mm/yyyy) / / Part-time (dd/mm/yyyy) / /

4.8 Have you been referred to a rehabilitation provider? ◯ Yes ◯ No

If **yes**, please provide details.

4.9 If you have not been referred to a rehabilitation provider, are you interested in vocational rehabilitation assistance (i.e. assistance with returning to the workforce)? ◯ Yes ◯ No

5. Hobbies, pursuits and pastimes

5.1 What were your regular hobbies, pursuits and pastimes prior to your disablement?

6. Illness/Injury

6.1 When were you first aware of your illness/injury? (dd/mm/yyyy) / /

6.2 What is the nature of your illness/injury?

6.3 If you suffer from an injury, how did it occur?

6.4 Have you previously suffered from the same or related illness/injury? ◯ Yes ◯ No

If **yes**, please provide details including dates.

7. Other medical conditions

7.1 Do you suffer from any other medical conditions for which you are consulting a health professional/provider? ◯ Yes ◯ No

If **yes**, please provide details.

8. Treatment

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

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

Name	Specialty	Contact details	Date from (dd/mm/yyyy)	Date to (dd/mm/yyyy)
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /

8.3 If you have been hospitalised as a result of the condition you are claiming, please provide details of your hospitalisation.

Name and address of hospital	Date admitted (dd/mm/yyyy)	Date discharged (dd/mm/yyyy)
	/ /	/ /

8.4 Please provide details of all treatment received to date, and outline any proposed treatment.

Treatment	Provider	Past	Current	Proposed
		◯	◯	◯
		◯	◯	◯
		◯	◯	◯
		◯	◯	◯
		◯	◯	◯

8.5 Please provide details of all treatment received to date, and outline any proposed treatment.

Medication	Dosage	Past	Current	Proposed
		◯	◯	◯
		◯	◯	◯
		◯	◯	◯
		◯	◯	◯
		◯	◯	◯

8.6 In the event that you have declined or deferred any treatment, please detail the treatment, the deferral period and reasons why the treatment has been deferred or declined.

9. Other income/benefits

9.1 Are you intending 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
Centrelink	◯ Yes	◯ No
Motor accident compensation	◯ Yes	◯ No
Life insurance	◯ Yes	◯ No
Common Law	◯ Yes	◯ No
Other insurance, superannuation fund, or financial institutions	◯ Yes	◯ No
Other government benefit(s)	◯ Yes	◯ No
Other (e.g. leave entitlements)	◯ 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)	**Reference number**	**Name and contact details of benefits provider**
$	/ /	/ /		
$	/ /	/ /		
$	/ /	/ /		

10. Additional comments

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 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

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

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

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.

I agree that a photocopy or a scanned, electronic copy of this authorisation shall be as effective and valid as the original.

Name (please print)

Signature

✗ Date (dd/mm/yyyy) / /

Please attach the following items with your completed form:

- Certified copy of your current driver's licence or passport.
- Copy of resignation/termination letter.
- X-ray and other radiology reports, pathology and other test results.
- Copies of medical reports in respect of the claimed condition.
- Hospital discharge summary (if hospitalised).
- Income Tax Return for the last financial year before you ceased work.

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