



Employer Statement

This form is to be completed by the Employer and relates to a claim for:

Total and Permanent Disability (TPD) Income Protection (IP) Both TPD and IP

This form should be completed in full as assessment of this claim may be delayed if the information provided is incomplete.

WHERE APPLICABLE, PLEASE ATTACH THE FOLLOWING WITH YOUR COMPLETED FORM

- Job description
- Rehabilitation reports and incident reports
- Sick leave payslips
- Proof of earnings (payslips) for the 12 months prior to the employee's last physical day at work
- Leave reports (annual leave, sick leave)
- Termination documents
- Any other information that will assist in the assessment of the claim

1. EMPLOYER DETAILS

| | | | |
|-----------------|----------------------|------------|----------------------|
| Name of company | <input type="text"/> | | |
| Street address | <input type="text"/> | | |
| Suburb | <input type="text"/> | State | <input type="text"/> |
| | | Postcode | <input type="text"/> |
| Phone number | <input type="text"/> | Fax number | <input type="text"/> |
| Email address | <input type="text"/> | | |

2. EMPLOYEE DETAILS

| | |
|---|---|
| <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other | <input type="text"/> |
| Given name(s) | <input type="text"/> |
| Surname | <input type="text"/> |
| Date of birth | <input type="text" value="DD / MM / YYYY"/> |

3. EMPLOYMENT DETAILS

a) What date did the employee join the company?

DD / MM / YYYY

b) What is the employee's job title?

c) What date did the employee cease all duties?

DD / MM / YYYY

d) What was the reason for the employee ceasing work?

e) What was the employee's base monthly salary + super prior to ceasing work?

\$

f) What was the employee's gross monthly salary prior to ceasing work?

\$

g) Please provide the components of the salary package.

h) Was the employee employed on a full-time, part-time, contractor or casual basis?

Full-time Part-time Contractor Casual

i) Please indicate the current employment status

Still employed On sick leave Resigned On workers comp Terminated

Other

j) Prior to the date the employee ceased all duties, was he/she working in a reduced capacity or on alternative or restricted duties?

No Yes → Please provide details including start/end date and title

k) Are there alternative duties the employee would be able to perform if they are unable to return to their normal duties?

No Yes → Please provide details

l) If yes, would you support a return to work program?

No Yes

m) Is there a return to work co-ordinator to assist the employee with a return to work program?

No Yes → Please provide details

