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MLC LIFE INSURANCE

Employer's Statement

Group Total and Permanent Disability (TPD)

If there is insufficient space to fully answer a question, please use page 4.
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Scheme Name or Employer (Business) Name

Policy Number/Member Number

Employee Details

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Name of employee

Date of birth
(DD/MM/YYYY)

Date started employment
(DD/MM/YYYY)

Date joined scheme
(DD/MM/YYYY)

Date of accident or start of illness
(DD/MM/YYYY)

Salary at date last worked
$

Date the employee was last actively at work
(DD/MM/YYYY)

Why did the employee stop work?

What is the current employment status of the employee? Please tick the appropriate box.

Working	☐		
On Leave	☐	What type	
On Compensation	☐	What type	
Redundant	☐	Date (DD/MM/YYYY)	
Terminated	☐	Date (DD/MM/YYYY)	
Resigned	☐	Date (DD/MM/YYYY)	
Deceased	☐	Date (DD/MM/YYYY)	
Other	☐	Date (DD/MM/YYYY)	

Provide details

Claim Details

1 Please provide a precise description of the injuries or nature of the illness and details of related leave already taken.

2 Employee's job title and description of duties (please provide a copy of the Job Description).

3 Are any qualifications/certificates or specialised skills required to perform this job?

No ☐ **Go to Question 4**

Yes ☐ Please provide details

4 Did the employee supervise other employees?

No ☐ **Go to Question 5**

Yes ☐ Please provide details and number of people supervised

5 Was the employee:

Full time ☐ Part time ☐ Casual ☐

6 What were the employee's usual hours and days of work in a week?

Hours worked per week

Usual days worked per week

Hours worked per day

From am/pm

To am/pm

Claim Details continued

7 Provide details of all leave taken during the two years prior to stopping work (include dates and types of leave). Please use page 4 if space is insufficient.

Type of leave

Dates from (DD/MM/YYYY) to (DD/MM/YYYY)

Type of leave

Dates from (DD/MM/YYYY) to (DD/MM/YYYY)

Type of leave

Dates from (DD/MM/YYYY) to (DD/MM/YYYY)

8 Were the employee's usual hours/days or duties modified in any way before they stopped work?

No **Go to Question 9**

Yes Please provide details

9 Please provide a full description of any previous positions the employee held with your organisation, including the periods spent in each position. Please use page 4 if space is insufficient.

Previous position

Dates from (DD/MM/YYYY) to (DD/MM/YYYY)

Previous position

Dates from (DD/MM/YYYY) to (DD/MM/YYYY)

Previous position

Dates from (DD/MM/YYYY) to (DD/MM/YYYY)

Additional Information

If you use this page to provide additional information, please note the page and question number to which the additional information refers.

Page Number	Question Number	Additional Information

Additional Information continued

10 Provide details of any workers' compensation claims this employee is currently making, or has made in the past.

Workers' compensation insurer name

Claim number

Address

Postcode

Claim start date
(DD/MM/YYYY)

Contact person

Gross weekly benefit
$

Time off work

Medical condition

Workers' compensation insurer name

Claim number

Address

Postcode

Claim start date
(DD/MM/YYYY)

Contact person

Gross weekly benefit
$

Time off work

Medical condition

11 If the employee is unable to resume their previous occupation, do you have any alternative or suitable work available?

No **Go to Question 12**

Yes Please provide details

Additional Information continued

12 Are there any other comments which you believe are relevant to the assessment of this claim?

Declaration and Authority

I declare that I am authorised to answer the above questions on behalf of the employer, and that to the best of my knowledge the above statements are true and correct. I acknowledge that:

- this information is provided for the primary purpose of the assessment and investigation of a claim under a policy with MLC Limited (the Insurer), and
- the Insurer may provide copies of this form to third parties, for example medical specialists or claims assessors from whom the Insurer seeks an independent report or to any other person deemed necessary to assist in the assessment or investigation of this claim.

Where this claim is made under a superannuation fund, I authorise MLC Limited to release a copy of this document and any information provided to the Trustee of the Fund.

Name of signatory (please print)

Signature under Common Seal or Rubber Stamp

Job title

Date

(DD/MM/YYYY)

Address

Postcode

Contact telephone number

Return this form and any attachments to:

Vision Super
PO Box 18041
Collins Street East
Victoria 8003

Email: insurance@visionsuper.com.au

MLCL200321-1121