

# Employer's Statement

## Income Protection

If there is insufficient space to fully answer a question, please use page 3. MLC Limited complies with Privacy Legislation available at [mlcinsurance.com.au/privacy-policy](http://mlcinsurance.com.au/privacy-policy).

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)

## 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 Was the employee:

Full time ☐ Part time ☐ Casual ☐

4 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

**5 Provide details of all leave taken during the two years prior to stopping work (include dates and types of leave). Please use page 3 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)

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

No

☐

Go to Question 7

Yes

☐

Please provide details

**7 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 3 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.**



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## 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)

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Address

										Postcode				
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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](mailto:insurance@visionsuper.com.au)