Claim for Insurance Benefit

EMPLOYER'S STATEMENT

To be be completed by the appropriate representative of the Claimant's Employer.

To enable the Fund Trustee and Insurer to consider a claim for your employee, could you please complete the following document.

Plan name | Member number | Policy number

Return the completed documents to AIA Australia Wholesale Life Claims PO Box 322 SILVERWATER NSW 2128

Section A – Employer details

Employer name

Employer's ABN

Employer address where claimant is working

State Postcode

Section B – Claimant's employment details

1. On what date did this employee commence employment?

/ /

2. On commencement of employment was the employee ☐ Full time ☐ Part time ☐ Casual?

Number of hours per week

3. On termination of employment (if applicable) was the employee ☐ Full time ☐ Part time ☐ Casual?

Number of hours per week

4. If there has been a change in the number of hours worked please provide details, including dates of when this change occurred

5. Gross annual salary as at date of disability?

$

6. On what date was this employee first unable to perform all of their normal duties because of the present disablement? (Medical Certificate supplied on cessation of work should be attached).

/ /

7. What was the last date the employee physically attended work in any capacity?

/ /

8. From your knowledge of the situation do you believe the employee will ever return to work? ☐ No ☐ Yes

9. What was the exact job title of the employee's usual occupation?

10. Please describe the exact duties performed (Please attach a job description and any additional information).

11. Please list below any machines or special equipment used by the employee. Were these machines operated manually or automatically?

12. Was the employee employed in a supervisory capacity?

☐ No ☐ Yes ▶ If 'Yes', how many staff did the employee supervise?

Section B – Claimant's employment details (continued)

13. Was the employee responsible for training and employing staff?

☐ No ☐ Yes ▶ If 'Yes', please provide details:

14. In what area did the employee work. e.g. office, loading dock, in the field, factory etc.?

15. What level of education or other qualifications does this job require, e.g. special courses etc?

16. Are you currently or have you previously been paying compensation benefits or other remuneration to the employee or, has any benefit been paid, or is any benefit due to be paid under the superannuation plan?

☐ No ☐ Yes ▶ If 'Yes', please provide details:

17. Are you aware of any benefits arising from the current disablement which the employee has claimed or is entitled to claim from any other source(s)?

☐ No ☐ Yes ▶ If 'Yes', please provide details:

18. Please indicate the status of the employee and provide copies of relevant correspondence if applicable.

On sick leave

☐ No ☐ Yes ▶ If 'Yes', please provide reason for sick leave

Has any sick leave been paid ☐ No ☐ Yes ▶ If 'Yes', please refer to question 20

Terminated

☐ No ☐ Yes ▶ If 'Yes', please provide reason and official date for termination

Retired (ill health)

Retired –ill health ☐ No ☐ Yes ▶ If 'Yes', what was the official date / /

Workers compensation

☐ No ☐ Yes ▶ If 'Yes', dates (from & to) / / / /

Other

☐ No ☐ Yes ▶ If 'Yes', please provide details, including any relevant dates

19. Has the employee been paid any benefits (e.g. sick leave)?

☐ No ☐ Yes ▶ If 'Yes', for what periods and amounts?

Type of benefit	From	To	Amount
	/ /	/ /	$
	/ /	/ /	$
	/ /	/ /	$

20. Does any of this benefit represent accrued sick leave? ☐ No ☐ Yes ▶ If 'Yes', please specify?

From	To	Amount
/ /	/ /	$
/ /	/ /	$
/ /	/ /	$

Section B – Claimant's employment details (continued)

21. If the employee had more than one job/position in his/her time with your organisation, please list all job titles and the time spent in each position.

Job titles	Dates
	/ /
	/ /

22. Could the employee's skills be used in any other type of work within your organisation?

☐ No ☐ Yes ▶ If 'Yes', provide details

23. If the employee should not be able to return to his/her regular occupation, do you have any alternative job openings?

☐ No ☐ Yes ▶ If 'Yes', provide details

24. What similar types of work would the employee's skills qualify him/her for?

25. Has the employee ever performed any light, alternate or modified duties?

☐ No ☐ Yes ▶ If 'Yes', please provide details of the duties performed and the dates these were performed?

Details	From	To
	/ /	/ /
	/ /	/ /
	/ /	/ /

26. Has the employee undergone any rehabilitation or a return to work plan?

☐ No ☐ Yes ▶ If 'Yes', please provide dates and full details, including provider names and contact details:

27. Did the employee resume pre disability duties and hours?

☐ No ☐ Yes ▶ If 'Yes' what date did they resume? / /

Remarks and/or additional information:

I declare that the answers to all questions on this form are true and correct and I have not withheld any relevant information.

Full name (please print in block letters)

Phone number ( )

Job title

Signature of person completing questionnaire ✗

Date / /

Please attach to this form copies of relevant duty statement(s) and position description(s), records or any other information that you are not able to provide above.