

This claim is made for:

Total and Permanent Disablement Claim (TPD)

Group Salary Continuance Claim (GSC)

or

Both TPD & GSC

IF INSUFFICIENT SPACE IS PROVIDED ON THIS FORM, PLEASE ATTACH YOUR ANSWERS ON A SEPARATE SHEET

Re: Employee's Name

Date of Birth

Scheme Name

Policy Number

1. What date did the employee cease all work duties
(note this date is not necessarily date of termination from Employment)

2. Why did the employee cease work?

3. Is the reason for ceasing work related to the accident/injury at work?

Yes

No

(a) If yes, was a Workers Compensation claim lodged?

Yes

No

(b) If so, please advise

Nature of illness/injury

Date/s involved

Name of Workers Compensation Insurer/company

Claim No or Reference

Contact Person, Ph no & Fax no

Address

(c) If not, why hasn't it been lodged?

4. Has the employee received any Workers Compensation benefits?

Yes
No

If yes, please provide date benefit commenced, amount received per month (Please supply a copy of payment print outs if available)

DD/MM/YY

\$

5. Fully describe employee's usual duties prior to ceasing work. Please provide a copy of Job Description.

6. Please advise which of the following were requirements of the claimant's normal duties:

Lifting over 5 kg	<input type="checkbox"/>	Prolonged Standing	<input type="checkbox"/>
Lifting over 10 kg	<input type="checkbox"/>	Kneeling/Crawling	<input type="checkbox"/>
Carrying up to 5 kg	<input type="checkbox"/>	Driving	<input type="checkbox"/>
Carrying over 5 kg	<input type="checkbox"/>	Supervising	<input type="checkbox"/>
Reaching above shoulders	<input type="checkbox"/>	Sitting	<input type="checkbox"/>
Bending	<input type="checkbox"/>	Walking	<input type="checkbox"/>
Climbing (i.e. ladders, scaffolding etc)	<input type="checkbox"/>		

7. Was the claimant confined to a set space or position at work?

Yes
No

If yes please advise details:

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8. Provide details of employee's education, training, qualifications and past employment if known

9. Was the employee performing light/alternative duties prior to ceasing work

Yes
No

If yes please indicate date commenced light duties

DD/MM/YY

Period of time performing these duties

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Lists of the duties performed and reasons for ceasing these duties

10. Is the employee's job still available for them to return to?

Yes
No

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11. If the employee is not expected to be able to resume in his/her usual occupation is the Employer prepared to consider alternative employment?

Yes

No

If no please state reasons

12. Is there any way that Tower can provide assistance (e.g rehabilitation) to allow the claimant to remain at work?

Yes

No

If yes, how we can assist

13. (a) What was the **gross basic** monthly salary prior to ceasing work

\$

(b) What was the **gross package** monthly salary prior to ceasing work. Please provide the components of the package

\$

14. What date did the employee start working with the company

15. What date did the employee join the Group Disability Scheme

If the employee did not join immediately at the time commenced employment, please state reasons for late joining of the Scheme/Fund

16. Please confirm either of the following

The above named employee was actively **at work** on the date they became **eligible to join the Plan**, performing their normal duties, or on normal recreation leave and in good health on that date

OR

The above named employee was not at work on the date they became eligible to join the Plan, due to sickness or injury, or workers compensation claim.

17. What was the basis of employment at commencement of employment?

Permanent Full Time.

Part-time. What is the Number of hours worked per week

Casual. Please provide duration of contract & No of hours worked per week

18. What was the basis of the employment at the time ceased work

Permanent Full Time Number of hours worked per week

Part-time Number of hours worked per week

Casual Number of hours worked per week

Please indicate the number of hours worked per week six (6) months prior to ceasing work

19. Please provide details of all leave taken by the claimant

(a) in the last six(6) months prior to commencement of the Policy with Tower

Date and duration of leave or absence	Reasons for leave or absence

(b) in the last twelve(12) months prior to the date ceased work

Date and duration of leave or absence	Reasons for leave or absence

If a doctor's certificate was provided when member ceased work, please provide a copy.

20. Please provide details of payments made to the claimant since cessation of duties. These should include payment type e.g Worker's compensation, Sick Leave, Holiday Pay etc.

Date Paid	Amount	Period Covered	Reason for Payment

21. Has the employee returned to work duties following the disability?

Yes
 No

If yes, what date ? Was this full time or part time?

If part-time please provide no of hours worked per week and details income

Details of duties performing

22. Is there any additional comment the Employer wishes to make in relation to this claim

Personal information is collected from you and your employees in accordance with your Duty of Disclosure to enable TOWER to provide you and your employees with the product or service you request. If you or your employees do not provide us with this information, we may not be able to provide you and your employees with this product or service.

In processing and administering, or at the time of an insurance claim, we may disclose employees' personal (including sensitive) information to a number of parties. These may include: health professionals, your or your employees Adviser or Financial Planner; other companies within the TOWER Group; the Insurance Reference Service; investigators; the Trustee (if applicable); the administrator of the fund; other insurers; reinsurers; government regulatory bodies; and lawyers and accountants (if applicable).

I declare the information I have provided to be accurate as against the business records held by the Company.

Name (please print)

Title

Name & Address of Company

Phone Number () Fax Number ()

Email Address

Signature Date

