August 2022

ZURICH

Group Salary Continuance Intermediate Claim Form Member's Statement

If there is insufficient space on this form, please use the space at the back of the form or attach a separate page. Please ensure that you identify the question for which the additional information relates to.

Claim number

Surname

First name(s)

Residential address

Suburb/Town State Postcode

Home phone Work phone

Mobile phone

Email

Since completion of the previous form:

1. Please list **dates** of consultations and names of **doctors** consulted.

2. Have you been hospitalised? If so, please provide details.

3. Has your treatment varied in any way? If so, please provide details.

4. Have you been involved in a rehabilitation or return to work program? If so, please provide full details including **name**, **address**, and **phone number** of the rehabilitation provider and **a summary of your progress.**

5. Are you entitled to, or are you receiving any payments from other forms of insurance, Workers' Compensation or Social Security? If so, please provide full details including **amounts**, **claim number**, **contact name**, **telephone number** and **address** of financial institution. Please enclose copies of your latest payment advices.

6. Please state the dates of continuous **total** disablement (i.e. not working in any capacity):

From (dd/mm/yyyy) / / To / /

7. If you are still **totally** disabled, when do you expect to return to:

Part-time work (dd/mm/yyyy) / / Full-time work (dd/mm/yyyy) / /

8. If you have returned to work in **any** capacity, please provide details of:

a. date of return to work (dd/mm/yyyy) / /

b. dates, hours and details of work performed

c. rate of weekly earnings

Important note: if you are claiming ongoing partial disablement benefits, you must attach a letter from your employer verifying the partial earnings and hours worked per week.

Declaration and Authority

I consent to the collection, use, storage and disclosure of my personal information (including health and other sensitive information) as described in Zurich's Privacy Policy, available at zurich.com.au/important-information/privacy

I acknowledge that I have been provided with Zurich's Privacy Statement, which provides information about how Zurich collects, uses and discloses my personal information (including health and other sensitive information), and I understand further information is available in Zurich's Privacy Policy available at zurich.com.au/important-information/privacy

If I have provided information (including health and other sensitive information) about another person in this application (for example a beneficiary or life insured), I declare that I have the consent of that person to do so. If I give Zurich personal information about someone else, I understand that Zurich requires me to show them a copy of the Product Disclosure Statement and Zurich's Privacy Policy so that they may understand the manner in which their personal information may be used or disclosed by Zurich and their related entities.

I hereby authorise any doctor, hospital, dentist, allied health professional or any other person whom I have consulted or has attended to me to release to Zurich or any other person approved by Zurich, and the trustee of the superannuation fund of which I am a member (if my claim is linked to such a fund), all information with respect to any illness, accident or injury, medical consultation, prescriptions of treatment and copies of all hospital or medical records, reports or notes.

I hereby authorise any employer, insurer or any other income provider, any accountant, lawyer or any other third party to release to Zurich and the trustee of a superannuation fund of which I am a member (if my claim is linked to such a fund), any information that it requires for the assessment of my claim.

I agree that any information or documents sought could also be used to investigate any non-disclosure or misrepresentation by me, such as at the time of applying for cover or to increase the amount or scope of my cover.

I agree that a photocopy or a scanned, electronic copy of this authorisation shall be as effective and valid as the original.

Signature

✗ Date (dd/mm/yyyy) / /

ZURICH

Group Salary Continuance Intermediate Claim Form Medical Attendant's Statement

If there is insufficient space on this form, please use the space at the back of the form or attach a separate page. Please ensure that you identify the question for which the additional information relates to.

Important note: if there is a fee for completion of this form it is the responsibility of the patient.

Patient's full name

Date of birth (dd/mm/yyyy) / /

1. What is the patient's current diagnosis?

2. What is the patient's prognosis?

3. What is the frequency of the patient's consultations, including date of last consultation?

4. What is the patient's current treatment?

5. Have there been any changes to the patient's condition or treatment over the past month or so? If so, please provide details.

6. Are there any steps that you would recommend to assist the patient in returning to work?

7. Has the patient recently been referred to any specialists? If so, please provide full details including the **name**, **address** and **telephone number** of the specialists and a **summary** of their comments. Please also attach copies of any reports in your possession.

8. If the patient is still **totally** disabled (i.e. not working in any capacity), when do you anticipate that he/she will be capable of returning to:

Part-time work (dd/mm/yyyy) / / Full-time work (dd/mm/yyyy) / /

9. If the patient is still **partially** disabled (i.e. working in a reduced capacity), when do you anticipate that he/she will be capable of returning to:

Full-time work (dd/mm/yyyy) / /

10. Have you certified the patient to return to work full-time? ○ Yes ○ No

a. If so, please indicate from which date (dd/mm/yyyy) / /

11. Any further comments?

Declaration

Your name

Qualifications

Address

Suburb/Town State Postcode

Email

Phone

Signature

✗

Date (dd/mm/yyyy)

/ /

Important note: please note that this report may be passed to third parties. The patient is a member of a Salary Continuance Plan and we are required to provide copies of all forms and reports to the Policy Owner, or Administrators, or to Industry regulatory bodies as required.

Phone: 1800 648 921
Email: group.claims@zurich.com.au
Website: zurich.com.au
GPO Box 75, Sydney NSW 2001