

PART A – DETAILS OF EMPLOYMENT

Complete this section only if you wish to CLAIM FOR LOSS OF EARNINGS.



PLEASE NOTE:

- A claim cannot be made unless the claimant was gainfully employed and working at least 20 hours a week at the date of injury.
- The Claimant must be continuously and totally disabled for more then the excess period noted in the Policy.
- The initial week of disablement is not covered.

Current Employer's Name _____

Current Employer's Address _____

State _____ Postcode _____

Contact Name _____

Telephone (AH) _____ Telephone (BH) _____

1. At the time of the accident were you *(please select as appropriate)*

Full Time Employee

Part Time Employee Working _____ hours per week

Self Employed on a full time basis _____

Period of Employment _____ / _____ / _____

2. What is your Occupation/Position? _____

3. What are your net Earnings per annum from this employer? _____

4. When did you cease work as a result of your injury? _____ / _____ / _____

5. Have you returned to work? **Yes** **No** *If Yes, when?* _____ / _____ / _____

6. Please give details of your entitlements (if any) to each of the following benefits:

	Number of Weeks		Weekly Amount		Total Entitlement
(a) Sick pay from your employer	_____	@	_____	=	_____
(b) Other insurance benefits including Personal Accident Policies	_____	@	_____	=	_____
(c) Centrelink	_____	@	_____	=	_____
(d) Other salary, wages, income or pay of any nature whatsoever being:	_____	@	_____	=	_____

*If other sources,
please describe briefly.* _____

Total Entitlements = _____

PART A – DETAILS OF EMPLOYMENT Continued.

7. What was your income from all sources in the twelve months period prior to your accident? **Total Annual Income from all sources** = _____
8. Have you worked at more than one place of employment within the twelve month period prior to your accident? **Yes** **No**

*If **Yes**, please provide details below showing full names and addresses – no abbreviations.*

(a) **Former Employer**

Contact _____ Telephone (BH) _____

Address _____

_____ State _____ Postcode _____

Occupation / Position _____

Period of Employment ____ / ____ / ____ to ____ / ____ / ____

(Please list any additional former employers on a separate list. Leave blank if not applicable.)

PART B – EMPLOYER’S STATEMENT - To be completed by Claimant’s current Employer

I _____ **Manager** **Accountant** **Director** **Partner**
(Name) please select title

of _____
(Name of Company)

at _____ State _____ Postcode _____

confirm that _____ has been employed continuously by
(Name of Employee)

this firm in the position of _____ since ____ / ____ / ____

His/Her gross earnings since the above date of employment (if less than 12 months ago) or for the past 12 months up to the date of his/her injury as described on this claim form amounted to \$ _____

At the ____ / ____ / ____ , the claimant was entitled to _____ sick days pay.
(Date of Injury)

I confirm that the claimant was not entitled to receive, nor did receive any form of remuneration whatsoever from this firm, his employer, in respect of his/her period of disablement commencing at the above-mentioned date of injury; except as follows:

Signature _____ Date ____ / ____ / ____

