## Section C – Employer's Statement (Must be completed by your employer paymaster/manager only)

Please ensure a **full 12 month wage report** prior to the disablement is attached with this form.
Please also ensure a **job description** outlining the employee's regular pre-disability occupational duties is attached with this form.

### Employee's Details

| | | | |
|---|---|---|---|
| **Employee's name** | | **Employee number** | |
| **Employee's Job Title** | | | |
| **Description of Injury or Sickness** | | | |
| **Employment type** | ☐ Full-Time ☐ Part-Time ☐ Casual ☐ Contractor ☐ Project Specific Work | | |
| **Current work status** | ☐ Employed ☐ Resigned ☐ Terminated | **Date Ceased** | |
| **Date commenced employment** | | **Date of Injury or Sickness** | |
| **Date last actively at work** | | **Date incapacity commenced** | |
| **Was the employee on alternative duties prior to the incapacity date?** | ☐ Yes ☐ No **If "Yes", from when?** | | |
| **Expected return to work date** | | **Employee's gross weekly earnings** | $ |
| **If the employee is fit for alternative duties are you prepared to take the employee back on alternative duties?** | ☐ Yes ☐ No | | |
| **In respect of this condition has your company completed any forms to any other insurance companies, workers compensation insurer or government benefit entities?** | ☐ Yes ☐ No | | |
| **If "Yes", please advise when and to which company** | | | |
| **Has the employee received any employer entitlements (normal pay, sick leave, annual leave etc.) since the incapacity commenced?**<br>**If "Yes" please complete details below and provide an additional wage report for the period** | ☐ Yes ☐ No | | |

| TYPE OF EMPLOYER BENEFIT | AMOUNT RECEIVED | DATE RECEIVED FROM | DATE RECEIVED TO |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| **Do you believe the employee's condition is work related?** | ☐ Yes ☐ No | | |
| **Does your company provide an EBA Income Protection policy?** | ☐ Yes ☐ No | **Insurer** | |
| **Is your company self-insured for workers compensation?** | ☐ Yes ☐ No | | |
| **Is the employee currently on workers compensation?** | ☐ Yes ☐ No | | |
| **Does your company top-up workers compensation claims?** | ☐ Yes ☐ No | | |
| **Name of Workers Compensation** | | **Policy No.** | |
| **If employee was employed on a specific work project** | **Project Name** | | |
| **Date commenced work on project** | | **Completion date of project** | |
| **Estimated Employment Completion Date of Injured/ Sick Employee (Employee estimated demobilisation date?)** | | | |
| **Was this employee stood down during the COVID-19 Pandemic?** | ☐ Yes ☐ No | | |
| **Did you register for the JobKeeper scheme?** | ☐ Yes ☐ No | | |
| **Was this employee on the ATO list for the JobKeeper payments?** | ☐ Yes ☐ No | | |

### Occupational Questionnaire

The following questions are in relation to your employee's regular occupation and typical duties performed.

| | |
|---|---|
| **Please advise pre-disability hours and days** | |

| Please provide details of the environment in which they work | |
|---|---|
| Are there any special skills, qualifications or licences required to perform their current occupation? Please specify | |

| Usual Duties | Frequency (% of job) | Comments |
|---|---|---|
| | | |
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## Employer's Declaration and Authority

**I am authorised to complete this form on behalf of the employer and all information I've supplied is true and correct. I also acknowledge that n2n Claims Solutions may provide copies of these forms to any required representative and/or third parties deemed necessary to assist in the ongoing assessment and management of the claim.**

| Company name | | | | | |
|---|---|---|---|---|---|
| Paymaster/Manager name | | Job title | | | |
| Address | | | | | |
| Suburb | | State | | Postcode | |
| Phone number | | Fax No. | | | |
| Email | | | | | |
| Signature | | | Date | | |