

## Section C – Employer’s Statement (Must be completed by your employer payroll/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	<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time	<input type="checkbox"/> Casual	<input type="checkbox"/> Contractor <input type="checkbox"/> Project Specific Work
Current work status	<input type="checkbox"/> Employed	<input type="checkbox"/> Resigned	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
In respect of this condition has your company completed any forms to any other insurance companies, workers compensation insurer or government benefit entities?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? If “Yes” please complete details below and provide an additional wage report for the period	<input type="checkbox"/> Yes <input type="checkbox"/> No			
TYPE OF EMPLOYER BENEFIT	AMOUNT RECEIVED	DATE RECEIVED FROM	DATE RECEIVED TO	
Do you believe the employee’s condition is work related?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Does your company provide an EBA Income Protection policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insurer		
Is your company self-insured for workers compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Is the employee currently on workers compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Does your company top-up workers compensation claims?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?)				

### 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	

What are the usual duties for their pre-disability position (e.g. supervisory duties, office duties, driving, essential physical i.e. lifting >10kg, etc.)		
Usual Duties	Frequency (% of job)	Comments

**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		