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	☐ 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? 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?)			

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**			