Employer Statement

This form is to be completed by the Employer and relates to a claim for:

☐ Total and Permanent Disability (TPD) ☐ Income Protection (IP) ☐ Both TPD and IP

This form should be completed in full as assessment of this claim may be delayed if the information provided is incomplete.

WHERE APPLICABLE, PLEASE ATTACH THE FOLLOWING WITH YOUR COMPLETED FORM

☐ Job description

☐ Rehabilitation reports and incident reports

☐ Sick leave payslips

☐ Proof of earnings (payslips) for the 12 months prior to the employee's last physical day at work

☐ Leave reports (annual leave, sick leave)

☐ Termination documents

☐ Any other information that will assist in the assessment of the claim

1. EMPLOYER DETAILS

Name of company

Street address

Suburb State Postcode

Phone number Fax number

Email address

2. EMPLOYEE DETAILS

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Given name(s)

Surname

Date of birth DD / MM / YYYY

3. EMPLOYMENT DETAILS

a) What date did the employee join the company? DD / MM / YYYY

b) What is the employee's job title?

c) What date did the employee cease all duties? DD / MM / YYYY

d) What was the reason for the employee ceasing work?

e) What was the employee's base monthly salary + super prior to ceasing work? $

f) What was the employee's gross monthly salary prior to ceasing work? $

g) Please provide the components of the salary package.

h) Was the employee employed on a full-time, part-time, contractor or casual basis?

☐ Full-time ☐ Part-time ☐ Contractor ☐ Casual

i) Please indicate the current employment status

☐ Still employed ☐ On sick leave ☐ Resigned ☐ On workers comp ☐ Terminated

Other

j) Prior to the date the employee ceased all duties, was he/she working in a reduced capacity or on alternative or restricted duties?

☐ No ☐ Yes → Please provide details including start/end date and title

k) Are there alternative duties the employee would be able to perform if they are unable to return to their normal duties?

☐ No ☐ Yes → Please provide details

l) If yes, would you support a return to work program?

☐ No ☐ Yes

m) Is there a return to work co-ordinator to assist the employee with a return to work program?

☐ No ☐ Yes → Please provide details

n) Are you aware of any other claims being lodged by the employee?

☐ No ☐ Yes → Please provide details

4. ADDITIONAL INFORMATION

We welcome any additional information or comments which may assist with the assessment of the claim.

5. PRIVACY STATEMENT

TAL is bound by obligations imposed by current privacy legislation. Information received or requested from you is handled in accordance with these obligations. TAL requires that all entities adhere to relevant privacy obligations when dealing with personal and sensitive information about our customers.

Print name

Job Title

Phone number

Signature of Authorised Officer

✗

Date DD / MM / YYYY

SUBMITTING THIS FORM

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If you have any questions, please contact us on 1800 101 019.