

**PART B
EMPLOYERS' STATEMENT
[GROUP RISK]**

This claim is made for:

- Total and Permanent Disablement (TPD)
- Group Salary Continuance (GSC)
- Or Both TPD and GSC

IMPORTANT NOTE:
THIS FORM SHOULD BE COMPLETED IN FULL AS ASSESSMENT OF THIS CLAIM MAY BE DELAYED IF THE INFORMATION PROVIDED IS INCOMPLETE. PLEASE HAVE THIS FORM COMPLETED BY THE EMPLOYEE'S DIRECT REPORT IF POSSIBLE

1. EMPLOYMENT DETAILS

(A) Name of Employer	<input style="width: 100%;" type="text"/>
(B) Address of Employer (head office)	<input style="width: 100%;" type="text"/>
Phone Number	<input style="width: 60%;" type="text" value="()"/>
Fax Number	<input style="width: 60%;" type="text" value="()"/>
(C) Address where Employee last worked	<input style="width: 100%;" type="text"/>
Phone Number	<input style="width: 60%;" type="text" value="()"/>
Fax Number	<input style="width: 60%;" type="text" value="()"/>

2. EMPLOYEE DETAILS

(A) Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms Other (specify) <input style="width: 50px;" type="text"/>
(B) Surname	<input style="width: 100%;" type="text" value="«M_Surname»"/>
Given name(s)	<input style="width: 100%;" type="text" value="«M_First»"/>
(C) Date of birth	<input style="width: 60%;" type="text"/>

3. EMPLOYMENT DETAILS

(A) Date Employee commenced employment	<input style="width: 60%;" type="text" value="/ /"/>
(B) Date Employee joined Plan	<input style="width: 60%;" type="text" value="/ /"/>
(C) What was the GROSS BASIC MONTHLY salary prior to ceasing work? (please provide last 2 payslips)	\$ <input style="width: 50px;" type="text"/> per month
(D) What was the GROSS PACKAGE MONTHLY salary prior to ceasing work?	\$ <input style="width: 50px;" type="text"/> per month
Please provide the components of the package?	
<input style="width: 100%; height: 20px;" type="text"/>	



(E) What is the Employee's employment status?

Self Employed Permanent Full Time Permanent Part Time
 Casual Other (incl unemployed) Please specify

(F) Please indicate the present status of the Employee and where applicable include date

Still employed Resignation Date / / Disability Leave Date / /
 Terminated Date / / Retirement Date / /
 Redundancy Date / / Other / /

(G) What were the average hours the employee worked per week prior to disablement?

hrs p/w

(H) Was the employee at work performing the usual duties of his / her occupation on the day the joined the Plan?

Yes No If No, please provide reasons

(I) What date did the employee cease all duties (please note this is not necessarily date of termination from employment)?

/ /

(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 If yes, please provide reasons

(K) What was the reason for the employee ceasing work?

(L) Are there alternative jobs that the employee would be able to perform if unable to return to their usual occupation?

No Yes If yes, please provide alternative occupation

If you answered yes, would you support a return to work programme?

No Yes

(M) Is there a return to work coordinator to assist the employee with an appropriate return to work plan? If yes please provide contact details

4. PHYSICAL WORK ENVIRONMENT AND JOB ACTIVITIES

(A) What is the employee's job title?

(B) Does the employee's job require work in any of the following conditions?

Outside	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, what percentage of time?	<input type="text"/>
In extremes of heat or cold?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, what percentage of time?	<input type="text"/>
In a damp or humid environment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, what percentage of time?	<input type="text"/>
In a noisy environment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, what percentage of time?	<input type="text"/>
In a dusty or unventilated environment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, what percentage of time?	<input type="text"/>
Around toxic fumes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, what percentage of time?	<input type="text"/>

(C) During the employee's normal routine, what percentage of time does the job require the employee to lift or carry the following weights:

	NEVER	1 – 25%	26 – 50%	51 – 75%	76 – 100%
23 KGS AND OVER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 TO 22 KGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
UNDER 9 KGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



(D) During the employee's normal routine, what percentage of time does the job involve the following activities:

	NEVER	1 – 25%	26 – 50%	51 – 75%	76 – 100%
WALKING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WALKING ON UNEVEN GROUND	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DRIVING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REACHING ABOVE SHOULDER HEIGHT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REACHING AT SHOULDER HEIGHT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REACHING BELOW SHOULDER HEIGHT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BENDING OR CROUCHING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KNEELING OR CRAWLING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(E) How much time is the employee required to maintain the following activities before changing position or activity:

	0 – 30 MINUTES	31-50 MINUTES	51-90 MINUTES	OVER 90 MINUTES
SITTING AT ONE TIME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STANDING AT ONE TIME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DRIVING AT ONE TIME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(F) During the average day, what is the number of hours the employee spends in the following positions or activities:

	0 – 2 HOURS	2 -4 HOURS	4 – 6 HOURS	6 – 8 HOURS
SITTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STANDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DRIVING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(G) What percentage of the employee's time is spent in the following activities:

TALKING	WRITING	SUPERVISING OTHER PEOPLE
%	%	%

(H) Are you aware of any other claims be lodged by or on behalf of the employee?

No Yes

If yes, please provide details

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**PLEASE ATTACH THE FOLLOWING WITH YOUR COMPLETED FORM.
PLEASE TICK THE BOX TO CONFIRM THE ATTACHMENTS.**

- Job Description
- Rehabilitation reports and plans
- Proof of earnings (last 2 payslips)
- Leave reports (annual leave, sick leave) for the past 12 months
- Termination documents
- Any other information that will assist in the assessment of the employee's claim

5. PRIVACY STATEMENT

Privacy laws protect the privacy of individuals. We request that any information received by or requested from you is handled in accordance with the regulations and the National Privacy Principles.

If you would like to know more about our Privacy Policy, please contact the TOWER Australia Limited Privacy Officer on (02) 9448 9416

Signature of authorised officer	<input type="checkbox"/> X <input type="checkbox"/>	Date	<input type="checkbox"/>
Name	<input type="checkbox"/>	Job Title	<input type="checkbox"/>

PLEASE FORWARD THE COMPLETED FORM TO:

Local Government Super
PO Box N835
GROSVENOR PLACE NSW 1220

