



## PROCEDURE FOR MAKING A CLAIM WITH WAGECOVER

Correct completion of these forms will assist us to make accurate and faster decisions regarding our customers' claim for benefits and ensure that where benefits are payable that they reach our customers in a timely manner. Incomplete claim forms will be returned for completion, leading to assessment delays

### IMPORTANT NOTE

**THERE ARE THREE SECTIONS TO THIS CLAIM FORM  
SECTIONS ONE, TWO AND THREE MUST BE COMPLETED IN ALL CASES.**

**Section one, CLAIMANT CERTIFICATION** is to be completed by the person making the claim (the sick or injured person)

**Section two, MEDICAL CERTIFICATION**, is to be completed by the registered medical practitioner who is/or has been involved in treating the person making the claim (ANY FEE INCURRED FOR COMPLETION OF THIS FORM BY THE DOCTOR IS THE RESPONSIBILITY OF THE PERSON MAKING THE CLAIM)

**Section three, FINANCIAL CERTIFICATION**, is to be completed by the person making the claim or their employer (see instructions in that section)

ALL SECTIONS OF THE CLAIM FORM MUST BE COMPREHENSIVELY COMPLETED  
BEFORE A CLAIM CAN BE ASSESSED.

**REMEMBER!**  
**YOU MUST ATTACH PROOF OF YOUR INCOME FOR THE  
FULL TWELVE MONTHS BEFORE YOUR SICKNESS OR INJURY**

(Acceptable proof is a full copy of your income taxation return and assessment for the twelve month period prior to the sickness or injury)

Once the claim form has been completed, signed and dated please send it, along WITH ATTACHMENTS, to:-

**WAGECOVER AUSTRALIA PTY LTD**  
PO BOX 590  
NEWPORT NSW 2106

If you have any inquiries, or if you need assistance with understanding or completing this form, you can Contact us on 9970 8411. Please ensure that you keep copies of all documentation.

**NOTE: This form is used to initiate a claim – if you continue to be disabled you will be sent further progress forms for completion and return on a regular basis**

**SECTION 1 CLAIMANT CERTIFICATION**

**THIS PART OF THE CLAIM FORM NEEDS TO BE COMPLETED BY THE PERSON MAKING THE CLAIM  
(THE SICK OR INJURED PERSON)**

Policy No: \_\_\_\_\_

Policy expiry date \_\_\_\_/\_\_\_\_/\_\_\_\_

**YOUR DETAILS**

First names: (Mr/Mrs/Ms) \_\_\_\_\_ Family Name: \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Medicare Number: \_\_\_\_\_

Where do you live? \_\_\_\_\_

Suburb/town \_\_\_\_\_ State \_\_\_\_\_ Post code \_\_\_\_\_  
(Note: We do not accept post office boxes as your address)

Address for correspondence \_\_\_\_\_

Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (M) \_\_\_\_\_

**DETAILS OF YOUR OCCUPATION**

What is your occupation? \_\_\_\_\_ How long have you been in this occupation? \_\_\_\_\_ yrs

How many hours do you work per week? \_\_\_\_\_ When did you join your current employer (date) \_\_\_\_/\_\_\_\_/\_\_\_\_

Which of the following are you? (please tick)

- An employee ( )
- Self employed ( ) Self employed, what is your business structure? (eg. Sole trader/ partnership/company) \_\_\_\_\_
- A contractor ( )
- A subcontractor ( )
- Other ( ) If so, please provide details here \_\_\_\_\_

By whom are you employed/or for whom do you work? (business or company name) \_\_\_\_\_

Employers address: \_\_\_\_\_

LIST HERE <b>ALL THE DUTIES</b> OF YOUR OCCUPATION AND THE AVERAGE NUMBER OF HOURS YOU PERFORM EACH DUTY <b>PER WEEK</b>	
Duty	Hours performed each week

How long have you been performing the duties listed above? \_\_\_\_\_

In what occupations did you work before your current one?

My occupation was \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_ (years)

My occupation was \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_ (years)

My occupation was \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_ (years)

## CONTINUATION OF SECTION ONE - DETAILS OF THE SICKNESS OR INJURY

**COMPLETE THIS PAGE ONLY IF YOU ARE CLAIMING FOR AN INJURY BECAUSE OF AN ACCIDENT. IF YOU ARE CLAIMING FOR A SICKNESS THEN YOU NEED TO COMPLETE THE FOLLOWING PAGE**

1. If you were injured, what is the injury? \_\_\_\_\_

2. Which part/s of your body were injured? \_\_\_\_\_

3. If you were injured please describe fully how the injury occurred: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. If you were injured, what is the street address where you were injured? \_\_\_\_\_

Town/suburb \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

5. If you were injured, were you working, or at work, at the time of the injury? \_\_\_\_\_

6. If you were injured were you travelling to, or from, work at the time of the injury? \_\_\_\_\_

7. If you were injured, what were you actually doing at the time you were injured? \_\_\_\_\_

\_\_\_\_\_

8. If you were injured, when did you first see a doctor for the injury and who was the doctor you first saw?

The first doctor I saw was \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_

9. If you were injured please tell us the time it happened \_\_\_\_\_ AM/PM and the date \_\_\_\_/\_\_\_\_/\_\_\_\_

10. Please nominate the names and addresses of two witnesses who saw you injure yourself

Name \_\_\_\_\_

Address \_\_\_\_\_ Ph: \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_ Ph: \_\_\_\_\_

11. Did you fully cease work as a result of this injury? \_\_\_\_\_ If so, on what date? \_\_\_\_/\_\_\_\_/\_\_\_\_

12. Was the answer given in response to question 9, the first time you have EVER injured this part of your body? \_\_\_\_\_

13. If you have EVER previously injured this part of your body please tell us where you were when it happened, the date and how it occurred? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

14. Which doctor, hospital or medical centre, if any, did you consult the previous time you injured yourself?

I previously saw Doctor \_\_\_\_\_ for injury to this part of my body on \_\_\_\_/\_\_\_\_/\_\_\_\_

15. Have you now, or previously, EVER made a claim for benefits of any type in regard to injury to this part of your body? (eg, worker's compensation, public liability, compulsory third party motor vehicle insurance, Centrelink, other insurer, etc) If so, provide full details here.

Claim made on (date) \_\_\_\_/\_\_\_\_/\_\_\_\_ - claim made against (organization) \_\_\_\_\_

Indicate the outcome of the claim here (eg, accepted, paid, declined, amount paid etc) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

16. Have you returned to work in any capacity yet? \_\_\_\_\_ If you have returned to work in any capacity, please state the date

on which you first returned here \_\_\_\_/\_\_\_\_/\_\_\_\_ and tick whether you returned in a full time or part time capacity below.

On the above date, I returned to work in part time ( ) or a full time ( ) capacity.

17. If you have not yet returned to work, when do YOU expect that you will be able to do so? \_\_\_\_/\_\_\_\_/\_\_\_\_

**NOTE:**  
**COMPLETE THIS PAGE ONLY IF YOU ARE CLAIMING FOR A SICKNESS – IF YOU ARE CLAIMING FOR A INJURY THEN YOU NEED TO COMPLETE THE PREVIOUS PAGE**

1. If you have/or had a **sickness**, what is the sickness? \_\_\_\_\_

2. If you have/or had a **sickness** when did you first experience the symptoms? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

3. What were the symptoms of the **sickness** that you **first** experienced? \_\_\_\_\_

4. Was your **sickness** caused, or contributed to, by work? \_\_\_\_\_ If so, how? \_\_\_\_\_

5. Did the **sickness** cause you to **completely** cease work? \_\_\_\_\_

6. If the **sickness** caused you to **completely** cease work, on what date did you **completely** cease work? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

7. When did you first see a doctor for the **sickness** and who was the doctor you first saw?

I first saw Doctor \_\_\_\_\_ on \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

8. Have you **EVER** had this **sickness or a similar sickness** before the period for which you are currently claiming? \_\_\_\_\_ If so, state when here \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

9. Have you **EVER** had **symptoms** of this **sickness or a similar sickness** before the period which you are currently claiming? \_\_\_\_\_ If so, state when here \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

10. If you had symptoms of this **sickness or a similar sickness** before the period which you are currently claiming, what were the symptoms, when did you have them and for how long did they last?

11. Have you **EVER** had medical advice or treatment for this **sickness or a similar sickness, or similar symptoms**, before the period for which you are currently claiming? \_\_\_\_\_ If so, when? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

12. If you have **EVER** had medical advice or treatment for this **sickness or a similar sickness, or similar symptoms**, before the period for which you are currently claiming, from whom and when did you obtain the advice or treatment?

I previously had medical advice or treatment for this sickness, or a similar sickness, or similar symptoms on \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

At the following doctor, medical practice or hospital; \_\_\_\_\_

13. Have you now, or previously, **EVER** made a claim for benefits of any type (eg.. worker's compensation, public liability, compulsory third party motor vehicle insurance, Centrelink, other insurer, etc) in regard to this sickness, or a similar sickness or symptoms? If so, provide full details here.

Claim made on (date) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ - claim made against (organization) \_\_\_\_\_

Indicate the outcome of the claim here (eg, accepted, paid, declined, amount paid etc) \_\_\_\_\_

14. Have you returned to work in any capacity yet? \_\_\_\_\_ If you have returned to work in any capacity, please state the date on which you returned here \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ and tick whether you returned in a full time or part time capacity below.

I returned to work in part time ( ) or a full time ( ) capacity.

15. If you have not yet returned to work, when do YOU expect that you will be able to do so? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

16. If you have not yet returned to work, how is the sickness currently actually preventing you from working? \_\_\_\_\_

**YOUR MEDICAL TREATMENT**

1. Were you admitted to hospital? \_\_\_\_\_ If admitted, which hospital were you admitted to? \_\_\_\_\_
2. On what date were you admitted to hospital? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ on what date were you released \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
3. Is the doctor that you have been seeing for your injury or sickness your usual treating doctor? \_\_\_\_\_ If not, how long have you been seeing this current doctor? \_\_\_\_\_
4. Who is your usual treating doctor and what is the address of their practice? \_\_\_\_\_  
\_\_\_\_\_
5. Have you been referred to a specialist? \_\_\_\_\_ Please provide the names and addresses of specialists you have been referred to.  
Specialists name \_\_\_\_\_ address \_\_\_\_\_  
Specialists name \_\_\_\_\_ address \_\_\_\_\_
6. If you have been referred to a specialist are you still consulting the specialist? \_\_\_\_\_
7. What medical treatment, including medication and therapies are you currently receiving and how frequently? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DECLARATION AND INFORMATION AUTHORITIES**

I understand that AFA Pty Ltd/Australian Family Assurance Ltd may need to access, collect and disclose information about me in order to be able to assess my claim for benefits. In order to do so, I (insert your full name here) \_\_\_\_\_ of (your address) \_\_\_\_\_

hereby authorize AFA Pty Ltd /Australian Family Assurance Ltd to collect and disclose information about me from and to the Health Insurance Commission, any insurance company, Centrelink, any hospital, physician, medical practice, any medical services provider, any medical therapy provider, any past or present employer, investigators, insurance reference bureau, financial institutions including banks, the Taxation Department or my accountant with respect to any sickness, injury, medical history, consultation, treatment including prescription of medication, copies of hospital medical records and tests and reports, medical practice records, vocational and employment records from past and present employers, copies of accounts and accountants statements including my taxation returns and assessments.

In providing or obtaining information about me, I understand that AFA Pty Ltd/Australian Family Assurance Ltd will use that information in the assessment of my claim, and that if I do not provide, or permit access to this information my claim may not be able to be assessed by AFA Pty Ltd/ Australian Family Assurance Ltd.

AFA Pty Ltd/Australian Family Assurance Ltd, may also collect and disclose information about me to:-

- It's relevant staff and contractors and service vendors involved in delivering services on behalf of AFA Pty Ltd/Australian Family Assurance Ltd.
- An agent or broker who collects the claim form from me, or who otherwise assists in facilitating the assessment of my claim
- It's re-insurers, or re-insurance brokers (which may include re-insurers or re-insurance brokers located outside Australia)
- It's legal service providers such as legal firms, or to accountants, actuaries, providers of medico-legal services, loss adjusters, auditors, Insurance Inquiries and Complaints Ltd (IEC Ltd) and claims management consultants.

By completing and returning this form to AFA Pty Ltd/Australian Family Assurance Ltd, I agree to AFA Pty Ltd/Australian Family Assurance collecting additional information from the parties specified above in connection with the assessment of my claim and agree to AFA Pty Ltd/Australian Family Assurance Ltd using and disclosing my information as set out above.

This consent to access, collect and disclose my personal information remains valid unless I revoke or alter it by giving AFA Pty Ltd/Australian Family Assurance Ltd, notice in writing and I agree that a photocopy of this authority is to be accepted and shall have the effect of an original.

I solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I have made any false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that all benefits under this policy shall be forfeited.

Signed \_\_\_\_\_

Dated \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## SECTION 2    MEDICAL CERTIFICATION

**THIS PART OF THE CLAIM FORM MUST BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER WHO IS CERTIFYING THAT THE SICK OR INJURED PERSON IS, OR WAS, DISABLED FROM WORKING.**

**PLEASE NOTE THAT ANY FEE INCURRED FOR THE COMPLETION OF THIS MEDICAL CERTIFICATION FORM IS THE RESPONSIBILITY OF THE PATIENT**

### PATIENT'S DETAILS

Patient's first name (Mr/Mrs/Ms) \_\_\_\_\_ Surname: \_\_\_\_\_

Patient's date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient's address \_\_\_\_\_

1. How long has the patient been known at your practice? \_\_\_\_\_ Years
2. Are you the patient's primary treating physician at your practice? \_\_\_\_\_  
If not, please provide details of the physician who is \_\_\_\_\_
3. What do you understand the patient's occupation to be? \_\_\_\_\_
4. What is the medical diagnosis for which the patient is claiming to be disabled from working? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. When did the patient **first** consult you in regard to this period of disability? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
6. When was the diagnosis reached? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
7. **Was there any previous history of this or of a similar condition?** \_\_\_\_\_ If so, please provide full details of the dates and the nature of the previous history of the illness or injury \_\_\_\_\_  
\_\_\_\_\_
8. If the patient sustained an injury, what were the circumstances of the injury?  
\_\_\_\_\_  
\_\_\_\_\_
9. On what date did the injury/accident occur? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

### SPECIFICS OF DISABILITY

1. On page one, of section one of this claim form, the patient has provided a breakdown of their occupational duties and the amount of time spent engaged in each duty per week. **In consideration of these duties and hours**, please provide the following information:-

	YES	NO	FROM WHAT DATE	TO WHAT DATE
Has the patient been <b>ENTIRELY PREVENTED</b> from engaging in their occupation by the medical condition?	(   )	(   )	____/____/____	____/____/____
Has the patient <b>ONLY BEEN PARTIALLY PREVENTED</b> from engaging in their occupation?	(   )	(   )	____/____/____	____/____/____
Is the patient now capable of a return to <b>FULL TIME</b> duties?	(   )	(   )	____/____/____	
Is the patient now capable of a return to <b>PARTIAL DUTIES</b> ?	(   )	(   )	____/____/____	

2. If the patient is not yet capable of returning to **FULL TIME DUTIES**, what is currently preventing them from doing so? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. if the patient is not yet capable of returning to **FULL TIME DUTIES**, when do you expect they can do so? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**CONTINUATION OF SECTION 2    MEDICAL CERTIFICATION**

**(FOR COMPLETION BY REGISTERED MEDICAL PRACTITIONER)**

4. If the patient is not yet capable of returning to **PARTIAL DUTIES**, what is currently preventing them from doing so? \_\_\_\_\_

\_\_\_\_\_

5. If the patient is not yet capable of returning to **PARTIAL DUTIES**, when do you expect they can do so?     \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

6. What duties of their occupation could the patient currently perform and for how many hours per week?

The patient could undertake \_\_\_\_\_ for \_\_\_\_\_ hours per week

The patient could undertake \_\_\_\_\_ for \_\_\_\_\_ hours per week

The patient could undertake \_\_\_\_\_ for \_\_\_\_\_ hours per week

The patient could undertake \_\_\_\_\_ for \_\_\_\_\_ hours per week

The patient could undertake \_\_\_\_\_ for \_\_\_\_\_ hours per week

7. Please list here details of any tests, x-rays, scans, pathology etc conducted to confirm the diagnosis

TEST	CONDUCTED ON	CONDUCTED BY	RESULT
_____	____ / ____ / ____	_____	_____
_____	____ / ____ / ____	_____	_____
_____	____ / ____ / ____	_____	_____
_____	____ / ____ / ____	_____	_____
_____	____ / ____ / ____	_____	_____

8. Has the patient been referred to a specialist? \_\_\_\_\_ Please provide name and contact details of the specialist \_\_\_\_\_

9. What is the current regime of medical treatment? (medication, therapies, surgery etc) \_\_\_\_\_

\_\_\_\_\_

10. **Are there any concurrent conditions**, which are affecting the patient's ability to return to work? (eg, depression/anxiety) \_\_\_\_\_

If so, please state here what the concurrent condition is and to what degree it prevents/restricts the patient returning to their occupation.

\_\_\_\_\_

11. Are you providing information in respect of this patient to any other insurer? \_\_\_\_\_ If so, which insurer? \_\_\_\_\_

\_\_\_\_\_

**DOCTOR'S DECLARATION**

The information provided in this medical certification is a truthful, comprehensive and frank account of the patient's medical condition, medical history and level of disability. I understand that if I have provided any false or misleading information in this medical certification, or if I have deliberately omitted information from this medical certification which has been requested and which I am able to give, it may result in a report to the Medical Registration Board or further action by the insurer, including civil action to recover compensation paid to the claimant in circumstances where reliance was placed on the accuracy and genuineness of the information I have provided.

Signed \_\_\_\_\_

Dated \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_ Qualifications \_\_\_\_\_

Address \_\_\_\_\_ Telephone No: \_\_\_\_\_

**SECTION 3 - FINANCIAL CERTIFICATION - IMPORTANT INSTRUCTIONS**

- 1. IF YOU ARE SELF EMPLOYED YOU MUST COMPLETE THE FIRST SECTION ON THIS PAGE
- 2. IF YOU ARE AN EMPLOYEE, CONTRACTOR OR SUB-CONTRACTOR, YOUR EMPLOYER OR PRINCIPAL CONTRACTOR MUST COMPLETE THE SECOND SECTION ON THIS PAGE.
- 3. YOU MUST PROVIDE PROOF OF YOUR INCOME FOR THE FULL TWELVE MONTHS BEFORE YOU BECAME SICK OR WERE INJURED

**CLAIMS WHICH ARE NOT ACCOMPANIED BY PROOF OF INCOME CANNOT BE ASSESSED**

**1. SELF EMPLOYED (if you are self employed, YOU must complete this section)**

What is the business/company name and from what address does it operate? \_\_\_\_\_

What activity has principally generated your income in the 12 months before sickness/injury? \_\_\_\_\_

Have you changed occupations in the 12 months before sickness/injury? \_\_\_\_\_ If so, please tell us what your occupation has changed from \_\_\_\_\_ to \_\_\_\_\_ and the date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Was any of the income you earned in the 12 months before the sickness or injury split with a spouse or partner? \_\_\_\_\_ If so, please provide the percentage here \_\_\_\_\_

What is your Accountants Name: \_\_\_\_\_ Accountants address: \_\_\_\_\_ Office telephone number: \_\_\_\_\_

Did you/your accountant complete and lodge a taxation return for both of the last two financial years? (circle) YES / NO

**2. AN EMPLOYEE If you are an EMPLOYEE, CONTRACTOR OR SUBCONTRACTOR then your employer or principal contractor must complete this section**

I, hereby certify that \_\_\_\_\_ has been engaged/employed by the company/business (name of sick or injured person)

since the date of \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ in the position of \_\_\_\_\_

	YES	NO	FROM WHAT DATE	TO WHAT DATE
Did the person <b>ENTIRELY CEASE WORK</b> in their employment position?	( )	( )	_____/_____/_____	_____/_____/_____

Did the person <b>ONLY PARTIALLY CEASE WORK</b> in their employment position?	( )	( )	_____/_____/_____	_____/_____/_____
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Has the person now returned to <b>FULL TIME</b> duties?	( )	( )	_____/_____/_____
---	-----	-----	-------------------

Has the person now returned to <b>PARTIAL</b> duties?	( )	( )	_____/_____/_____
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Are there light or partial duties available within the company/business in which the person can work? \_\_\_\_\_

If so, please state what duties are available and what hours the person could be alternately engaged by the company/business \_\_\_\_\_

During the period of incapacity did he/she receive any of the following: -

- ( ) Paid sick leave from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ in the amount of \$\_\_\_\_\_ per week
- ( ) Paid holiday pay from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ in the amount of \$\_\_\_\_\_ per week
- ( ) Workers compensation from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ in the amount of \$\_\_\_\_\_ per week
- Other (please specify) \_\_\_\_\_ from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ in the amount of \$\_\_\_\_\_ per week

Your name: \_\_\_\_\_ your role: \_\_\_\_\_ (Supervisor/paymaster/human resources manager/owner/ manager)

**IN THE EVENT THAT THE CLAIM IS APPROVED PLEASE CIRCLE TO WHOM THE PAYMENT IS TO BE MADE OUT TO**

**EMPLOYER EMPLOYEE**

Company/business name and address: \_\_\_\_\_

Telephone No: \_\_\_\_\_ Fax No: \_\_\_\_\_

Signed \_\_\_\_\_ Dated \_\_\_\_\_

(Note: where the claimant is an employee of a Pty Ltd company the company seal must be affixed in this section)