

## Employer's Statement - Total & Permanent Disablement (TPD) claim

Complete, sign and post this form to Maritime Super, Locked Bag 2001, QVB Post Office NSW 1230.

### PART A – COMPANY DETAILS

#### Employer Details

Employer Name (Business Name)

Employer Trading Name (if different)



Registered Address

### PART B – EMPLOYEE'S DETAILS

#### Employee Details

Payroll Number

Title (Mr/Mrs/Ms/Miss etc)

Gender




Male

Female

Surname

Given Names



Residential Address

Date of Birth

Date Employee joined Company

Date Employee joined Maritime Super

 /  / 
 /  / 
 /  / 

Annual salary at date last worked (including overtime, bonus allowance etc)

\$

#### Details of Employee's Occupation, Education and Experience

What was the Employee's usual occupation?

What was the nature of their employment?

Full-time

Part-time

Casual

Describe their usual duties:



Confirm the physical requirements of the role (where applicable) by completing the table below

Percentage of time spent in task

Percentage of time spent in task

Task	<30%	31% - 70%	> 71%	Task	% time spent per day
Lifting – 20kg and over	<input type="text"/>	<input type="text"/>	<input type="text"/>	Walking	<input type="text"/>
Lifting – 7kg-19kg	<input type="text"/>	<input type="text"/>	<input type="text"/>	Standing	<input type="text"/>
Lifting – under 7kg	<input type="text"/>	<input type="text"/>	<input type="text"/>	Climbing (ladders, scaffolding etc)	<input type="text"/>
Carrying – 20kg and over	<input type="text"/>	<input type="text"/>	<input type="text"/>	Crawling	<input type="text"/>
Carrying – 7kg-19kg	<input type="text"/>	<input type="text"/>	<input type="text"/>	Kneeling	<input type="text"/>
Carrying – under 7kg	<input type="text"/>	<input type="text"/>	<input type="text"/>	Climbing (ramps, setups etc)	<input type="text"/>
Reaching above shoulders	<input type="text"/>	<input type="text"/>	<input type="text"/>	Sitting	<input type="text"/>

Member's Full Name

Company Name

What trades, apprenticeships, qualifications or skills do they have?



What roles has the Employee held within the Company?

Job Title

Period

Nature of duties





Job Title

Period

Nature of duties





Job Title

Period

Nature of duties





Are there any alternative roles available, or could the Employee's skills be used in any other work?

Yes (specify below)

No

If you answered 'Yes' to the question directly above, please specify roles:



### Claim Details

On which date did the Employee last physically work, performing their normal duties?

 /  / 

Was the Employee on restricted/partial duties prior to the date they ceased work?

Yes (specify below)

No

If you answered 'Yes' to the question directly above, please provide details:

On which date did the restricted/partial duties commence?

 /  / 

Provide details of the restrictions imposed:



On which date did the restricted/partial duties cease?

 /  / 

What is the nature of the Employee's injury or illness?

On which date did the injury or illness first cause disablement?

 /  / 

Has the Employee resigned from employment?

Yes (specify below)

No

If 'Yes', please provide the date of resignation

 /  / 

Were you notified that the Employee was certified unfit prior to their ceasing work?

Yes (specify below)

No

Member's Full Name

Company Name

Has rehabilitation been attempted?

Yes (specify below)

No

Rehabilitation Provider

  
  
  
  


Roles undertaken

  
  
  
  


Period of Rehabilitation

  
  
  
  


Please provide details of all leave taken by the Employee in the 12 months prior to their ceasing work:

Sick leave –period(s)

Annual leave –period(s)

Other leave –period(s)

Please provide details of any payments made to the Employee since they ceased work (e.g. superannuation, workers compensation, sick leave etc).

Type of payment

  
  
  
  


Period of payment

  
  
  
  


Amount

  
  
  
  


Has any other claim been lodged for a Total and Permanent Disability benefit?

Yes (specify below)

No

If you answered 'Yes' to the question directly above, please provide details:

Claim Number

Name of Insurer

Address of Insurer

Any other information/comments:



### Employer's Declaration

I confirm that I am authorised to answer the questions in this statement on behalf of the Employer named below.

I declare that this information is true and correct to the best of my knowledge.

Authorised Representative's Signature

Date

 / 

Authorised Representative's Full Name

Job Title

Employer's Address

Phone Number

Fax Number

Email Address