

Disablement & ill health claim

Employer Statement



Strictly private and confidential

About this form

This form is to be completed by the Employer to assist Equip to determine whether the member is eligible for a disablement, ill health and, in the case of a Rio Tinto employee, a D&D scheme benefit. It is important that you read the form carefully and answer all questions clearly and accurately.

1 – Basic employee and claim details

Please complete in pen using CAPITAL letters

Title Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of birth (ddmmyyy) <input type="text"/>	Member number (if known) <input type="text"/>
First name <input type="text"/>	Last name <input type="text"/>	Date joined employer <input type="text"/>	Date joined fund <input type="text"/>
Date last physically attended work <input type="text"/>	Salary at date last worked \$ <input type="text"/> , <input type="text"/>		

A. Is the claim based on:

Injury - date of accident

Illness - date of onset of illness

Nature of illness/injury (causing member to cease work)?

Any other known medical conditions?

B. Has the employee been formally terminated?

Yes - date of termination

No - current employment status of the employee (✓ select one option only below)

On sick leave On unpaid leave On maternity leave On Workers Compensation

Period from

C. For Rio Tinto employers only

Is the member entitled to a D&D benefit? Yes No

If yes, does the employer support payment of a D&D benefit? Yes No - please provide details of your reason below:

Need help?

Call us on 1800 682 626 or www.equipsuper.com.au Equip, GPO Box 4303, Melbourne VIC 3001

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Publication No: ESF_InsC_SelfIns_TPD_IllHealth_EmprStm_0120

L. Please ✓ column A, B or C as applicable to their normal duties and also enter a % in column D

Job activities	A (occasional) 1/3 of time or less	B (frequent) Up to 2/3 of time	C (continuous) more than 2/3 of time
Lifting 20 kgs & over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 7- 19 kgs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting Under 7 kgs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying 20 kgs & over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying 7- 19 kgs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching above shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching below shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Job activities	D Percentage per day
Walking	<input type="text"/> <input type="text"/> <input type="text"/> %
Standing	<input type="text"/> <input type="text"/> <input type="text"/> %
Sitting	<input type="text"/> <input type="text"/> <input type="text"/> %
Climbing - ladders, scaffolding, ramps, steps, etc.	<input type="text"/> <input type="text"/> <input type="text"/> %
Crawling	<input type="text"/> <input type="text"/> <input type="text"/> %
Kneeling	<input type="text"/> <input type="text"/> <input type="text"/> %
Driving	<input type="text"/> <input type="text"/> <input type="text"/> %

M. Can the activities in the above table be modified as part of a light duties program?

Yes - please provide details below No

N. Why did the employee cease to perform their normal duties on a full time basis?

3 – Modified or light duties or alternative roles (only complete for illness or injury claim)

A. If the employee is unable to resume their normal duties, is there any other alternative or suitable work available?

Yes - please provide details below No

B. At the date last physically worked, was the employee performing modified or light duties or an alternate role?

Yes No

C. Describe in detail, the modified or light or alternate role the employee was performing.

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D. At anytime during the employee's employment, was the employee offered modified or light duties or an alternate role?

Yes - please complete the table below

No

	Offer 1	Offer 2
Date of offer? (ddmmyyyy)	<input type="text"/>	<input type="text"/>
Role offered?		
Reason for offer?		
Duties/role offered to the employee?		
Were the duties/role?	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Casual	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Casual
Did the employee accept or reject the offer?	<input type="checkbox"/> Accepted <input type="checkbox"/> Rejected	<input type="checkbox"/> Accepted <input type="checkbox"/> Rejected
If rejected, what reason or explanation was given by the employee for not accepting the offer made by the employer of modified/ light duties or alternative role?		

E. If modified or light or alternate duties were **not offered**, please explain why below.

4 – Employment and education history (only complete for illness or injury claim)

A. Please provide a full description of any previous positions the employee held with your organisation, including the periods spent in each position.

Previous position	Start date	End date
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>

B. Does the employee hold any industry qualification/certificates?

C. What, if any, computer, administrative, or other skills does the employee have?

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D. What level of education, training or experience was the employee required to have in their position?

E. What level of education does the employee have?

5 – Cessation of employment (only complete for illness or injury claim)

A. What was the reason for terminating employment?

Illness Injury Retrenchment Voluntary Other - *please provide details below*

B. Who was the employee's employment terminated by?

Employee Employer

C. At the date the employee last physically attended work, could the employee perform their normal duties?

Yes No - *please provide details below*

D. Was the employee considered for other suitable roles with the employer as an alternative to terminating employment?

Yes No - *please provide details below*

E. List all dates the employee was absent from work due to illness or injury during the twelve months prior to the date last physically worked.

Date	Reason

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6 – Additional information

Please confirm if any of the following documents are available should Equip request them. It can help speed up our processing of this claim if you can attach them now.

- Job description of employee Available Attached
- Job description of any modified/light or alternative roles Available Attached
- Any offers of alternate modified/light or alternative roles Available Attached
- All relevant medical reports/leave certificates received Available Attached
- Any termination letter (including redundancy) Available Attached

Provide details of any other matters or comments you wish to make in respect of the employee's claim

Privacy

The personal information you provide on this form will be used in accordance with Equip's Privacy Statement, which you can view online at www.equipsuper.com.au/privacy or you can obtain a copy by contacting us on 1800 682 626.

If you have any other queries in relation to privacy issues, you can contact us or write to our Privacy Officer, GPO Box 4303, Melbourne VIC 3001.

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7 - Employer contact information and declaration

Contact person

Business unit

Address (must be provided)

Suburb

State

Postcode

HR representative

First name

Last name

Contact telephone

Email

Employer declaration

We hereby declare that to the best of our knowledge and belief the above answers and statement are true and correct.

We acknowledge that the Fund and its insurers may provide copies of this form to third parties, for example, medical specialists or claims assessors from whom it seeks an independent report, or to any other person deemed necessary to assist in the assessment or investigation of this claim.

Signature of person completing employer statement:

Date (ddmmyyyy)

Contact telephone

Print name

Title

Signature of General Manager or above:

Date (ddmmyyyy)

Contact telephone

Print name

Title

Please return this form and any attachments to Equip, GPO Box 4303, Melbourne Vic 3001.

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