Your insurance

A delay in providing us with the required documents (including your certified ID and bank details), may lead to a delay in making payment to you.

Income Protection Claim Kit

When you need to make a claim on your Income Protection insurance, the more straightforward the process, the better.

This checklist will help you keep track of the paperwork contained in this kit that you need to complete.

What you need to complete

- [ ] MetLife claim form
- [ ] Tax file number declaration
- [ ] EFT payment instructions
- [ ] AON/AHI authority form

What your doctor needs to complete

- [ ] MetLife general medical statement

Other documents you need to provide

- [ ] Certified identification documents for SA Power Networks
- [ ] Certified identification documents for ElectricSuper
  Certified copies of your Driver's Licence or passport (or an acceptable alternative) must be provided to pay your benefit if your claim is approved. For more information please see www.electricsuper.au/resources/completing-proof-of-identity
- [ ] Front page of your bank statement

What your employer needs to provide

- [ ] SAPN Employer Statement
- [ ] Relevant payslips
- [ ] MetLife employer's statement

When complete, submit your forms to:

SA Power Networks

SA Power Networks will work with ElectricSuper to process your claim as quickly as possible.
It may take a few weeks to process your claim.
Submitting a claim does not guarantee that your claim will be paid.

electric super

SA Power Networks

Initial Information Form for Income Protection Insurance Claim

We want to make this process as easy as possible, so please:

- **Complete all sections of the form in full.** An incomplete form will delay our review as we may need to contact you for further information or return the form to you to complete in full. Use the 'Additional comments' section if you need more space to answer a question.
- **Review the checklist below** and ensure all supplementary information is provided. If you don't send this information, we will not be able to complete our review. Before you start we recommend you gather the documents on the checklist to assist you with completing this form.
- It is **important** that you answer the questions below honestly, completely and to the best of your ability. If you are unclear on any question, please contact us. Providing misleading or incomplete answers could lead to your claim being delayed or declined.
- If you **require assistance** or further information please call MetLife on 1300 555 625 and a claims expert will be able to help you complete the form and answer any questions you may have about why the information is required and how it may be used.

Please note that issuing this form is not an admission of liability.

Claim checklist and mandatory requirements

The below checklist will help you ensure that you have all the information we require to assess your claim. Please ensure you have gathered all the requirements before forwarding this form to us. There may be additional information required specific to your claims circumstance, this information will be detailed within the attached covering letter.

Note: Once you have provided this form to us with the additional requirements as set out below, further information may be asked from you at a later time. The case manager who is assigned to your claim will ensure they explain to you what information is required and what the information will be used for.

We will need the following information before we start our review:

- ☐ **Proof of identification -** A certified copy of your passport or driver's licence.
- ☐ **Any other documents -** Provide any additional documents you think might assist with your claim such as insurance or compensation reports.
- ☐ **Medical Statement and Medical Reports -** Please have your treating medical practitioner complete the enclosed Medical Statement and provide any medical reports, scans, referrals letters or any other medical information that you have available.

  Important: Please note that we cannot start the assessment of your claim until we are provided with medical information in support of your claim.
- ☐ **Completed Authority** on page 9 to release health information and other information from third parties - This provides us with authority to collect and use information to assess and manage your claim.
- ☐ **Tax File Number Declaration** - If your income policy is held under superannuation, the benefits paid will be taxed before payment. For further information on your tax liability please speak with a financial advisor or tax agent.
- ☐ **Australian Business Number (ABN)** - If you are self-employed or own part or all of the business you work for.
- ☐ **Payslips** - We require payslips for the 12 months immediately prior to your date of disability and the date last worked, and any payslips you received after this, as well as any relevant PAYG certification.
- ☐ **Full Income Tax Return and Notice of Assessment** - Please provide these for the relevant period including the tax period immediately prior to your date of disability and dates last worked, and also your Business Tax Return if completed.
- ☐ **I have completed all sections of this form.**

Privacy - Use and disclosure of personal information

Your privacy with MetLife Insurance Limited ABN 75 004 274 882 AFSL 238096 ('MetLife' or the 'Insurer')

The personal information you provide in the form is necessary for MetLife to provide you with the products and services you have requested from MetLife, and to manage your claim. You do not have to provide MetLife with your personal information, but if you do not do so MetLife may not be able to provide you with the products or services. MetLife complies with the Privacy Act 1988 and the principles laid out in its Privacy policy which details information about the entities that MetLife usually discloses personal information to (including overseas recipients), how you may access or seek correction of your personal information, how we manage that information and our complaints process. MetLife's Privacy Policy is readily available and can be viewed at www.metlife.com.au/privacy.

Section 1. Declaration and authority

I declare that the answers and statements made on this claim form are true and complete. I have not made any false or misleading statements and have included all information relevant to the assessment of my claim. I understand that making false or misleading statements to claim insurance benefit is fraud and is a criminal offence.

In the event of a fraudulent claim MetLife reserves the right to: decline the claim, and/or cancel all cover held by the Life Insured with MetLife in accordance with the Insurance Contracts Act.

Where I have completed this declaration and authority as the Guardian/Attorney, I have attached a certified copy of the relevant legal documents (e.g. Power of Attorney). If any of the answers have not been completed by myself, I certify that I have checked them and they are correct.

I have read and understood the Privacy Disclosure Statement entitled 'Privacy - Use and Disclosure of personal information'. I consent to the collection, use and disclosure of my personal (including sensitive) information in accordance with the terms of these documents.

I understand and agree that if I do not give the information requested by MetLife or its representative, MetLife may not be able to assess, investigate or pay my claim.

Signature ▶	Date *(dd/mm/yyyy)*

Full name (please print)

Section 2. Personal details

Policy number/fund member number (*if applicable*)

Title	Given name(s)

Surname	Previous name(s)

Address	Suburb	State	Postcode

Preferred contact number	Email

Gender	Date of birth *(dd/mm/yyyy)*
☐ Male ☐ Female ☐ Indeterminate, Intersex, Unspecified	

Section 3. Details of medical condition

Benefits under your policy are paid based on your inability to work due to a medical condition. Please detail all your medical conditions below, we will use this information to assist us in understanding how your condition is impacting you.

1. Please detail all medical conditions impacting your ability to function.

What is the medical condition(s) that caused you to be unfit for work?	Date symptoms commenced	Date you first consulted a medical practitioner	Date of disability (the date your doctor first certified you as medically unfit for work)
	/ /	/ /	/ /
	/ /	/ /	/ /
	/ /	/ /	/ /

Section 3. Details of medical condition (continued)

2. Is your condition caused by or related to an accident? ☐ Yes ☐ No

If Yes, please provide details of the accident including date, location and activity performed:

3. What was the date you were last at work performing any work duties (*dd/mm/yyyy*)? / /

4. Have you ever had this/these medical condition(s) or similar before? ☐ Yes ☐ No

If Yes, please provide details:

5. What usual daily activities are you unable to do as a result of your medical condition(s)? e.g. home duties, social activities, etc.

6. Have you had any treatment for your condition? ☐ Yes ☐ No

If Yes, please provide details of treatment that has been prescribed:

7. Please detail all home-based exercises or activities that have been recommended or instructed by your treatment providers. Please include; nature of activity, frequency of activity, your level of success in completing the activity, how the activity is impacting your recovery:

8. Provide the details of all medical practitioners, including allied health professionals, treating you for this/these condition(s). Please attach copies of any letters or referrals you have available:

Doctor's name	Doctor's address, phone number and email	Specialty	Date first consulted	Date last consulted	Usual Doctor (Yes/No)
			/ /	/ /	
			/ /	/ /	
			/ /	/ /	

Section 4. Employment and return to work

We will use this information to assist us in understanding how your condition has impacted on your ability to work.

9. Have you returned to work in any capacity, whether paid or unpaid (e.g. voluntary work), since you first ceased work? ☐ Yes ☐ No

If Yes, please provide details.

Start date	End date	Duties and hours performed
/ /	/ /	
/ /	/ /	
/ /	/ /	

10. Is your job available to return to? ☐ Yes ☐ No

If No, please tell us why it is unavailable:

11. If you have not yet returned to work, when do you hope or expect to return to work (*dd/mm/yyyy*)? / /

12. If you can perform all of your usual duties but are only able to work reduced hours, please specify the hours and days:

How many hours per day could you work?

How many days per week could you work?

13. If you could safely perform your role with reduced or modified duties, please detail what duties you remain capable of performing:

14. Are there any other challenges or issues that may prevent you from returning to work?

Section 5. Income details

15. Have you received any income since ceasing work? ☐ Yes ☐ No

16. Please provide details of any money or income you have received since ceasing work from any sources such as superannuation benefits, Workers' Compensation, sick or annual leave, ongoing business income, other insurance payments or Centrelink benefits:

If available, you can provide copies of payment letters or schedules in place of completing the below table.

Type of payment	Payment start date	Payment end date	Amount per week	Is this payment expected to continue?
	/ /	/ /		☐ Yes ☐ No
	/ /	/ /		☐ Yes ☐ No
	/ /	/ /		☐ Yes ☐ No

Section 6. Occupation and duties

17. Please detail your most recent occupation/role.

Occupation/Job title	Full-time/ Part-time/Casual/ Contract/ Self-employed	Industry	Date started (*dd/mm/yyyy*)	Date finished (*dd/mm/yyyy*)
			/ /	/ /

18. Please include any specific work skills as a part of main duties, e.g. supervise others, telephone or face-to-face customer service, cash handling, equipment/tools used, etc.

Please include detail of your employment status (full-time, part-time, etc.) and the hours and days worked per week:

Main duties

19. Were you employed or self-employed in your most recent occupation? ☐ Self-employed ☐ Employed

20. If you were employed, please provide the name and contact details of your supervisor or HR contact:

Name	Role	Contact number	Email

21. If you were self-employed in your prior occupation, please provide details below:

Business trading name	ABN	% Owned by you

22. If you're self-employed, is your business still trading? ☐ Yes ☐ No

If Yes, please provide detail in relation to your ongoing involvement in the business:

If No, when did it stop trading (*dd/mm/yyyy*)? / /

Section 7. Tasks and duties

23. Please complete the following table on how physical your role was, detailing the time per day required of each physical task. If your role varied day to day, please provide in comments on an 'average' day:

a) Sitting ☐ Over 4 hours ☐ 4 hours ☐ 2 hours ☐ 60 minutes ☐ 30 minutes ☐ Nil

Additional comments:

b) Standing ☐ Over 4 hours ☐ 4 hours ☐ 2 hours ☐ 60 minutes ☐ 30 minutes ☐ Nil

Additional comments:

c) Walking ☐ Over 4 hours ☐ 4 hours ☐ 2 hours ☐ 60 minutes ☐ 30 minutes ☐ Nil

Additional comments:

Section 7. Tasks and duties (continued)

d) Lifting	☐ Over 20kg	☐ Up to 20kg	☐ Up to 15kg	☐ Up to 10kg	☐ Up to 5kg	☐ Minimal (1 - 2kg)

Provide detail on lifting position e.g. from floor/ bench, one/two arms

e) Driving	☐ Over 4 hours	☐ 4 hours	☐ 2 hours	☐ 60 minutes	☐ 30 minutes	☐ Nil

Additional comments

f) Travelling by other means e.g. public transport	
g) Pushing/pulling	
h) Bending/twisting/ squatting	
i) Reaching	
j) Fine motor e.g. computer use, gripping	
k) Other (please specify)	

Section 8. Hobbies, pursuits, volunteer work and pastimes

24. What were your regular hobbies, pursuits and pastimes prior to your disablement?

25. Within the last 5 years, have you regularly performed volunteer work activities? ☐ Yes ☐ No

If Yes, please provide details:

Section 9. Language

26. Please indicate your level of English skills:

	Below average	Average	Above average
Speaking	☐	☐	☐
Writing	☐	☐	☐
Reading	☐	☐	☐

27. Is English your first language? ☐ Yes ☐ No

28. Are you interested in re-training? ☐ Yes ☐ No

If Yes, please provide details:

Section 10. Other insurance or claims

29. Have you currently lodged or might you lodge a claim under Workers' Compensation or under any other superannuation or insurance policies? ☐ Yes ☐ No

If Yes, please provide details below:

Name of fund/insurer	Address, phone number and email	Claim number	Payment amount	Benefit type

30. In addition to the above, have you ever had any previous Workers' Compensation, Disability Insurance, TPD, Trauma Insurance claim paid or declined? ☐ Yes ☐ No

If Yes, please provide details including insurer and what was claimed.
If available, please provide copies of any letter or other correspondence that outlines the claim.

Section 11. Claim payment (EFT)

Full name of account holder/payee

Name of bank	BSB number	Account number

NOTE: Payment direct to you is only available if the policyholder has given permission for this. If your policy is under superannuation, the policyholder is the Trustee of the Superannuation Fund.

Additional comments

Releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, MetLife, collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Please read each Authority carefully and the explanatory notes below.

Authority 1 explanatory notes – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Authority 2 explanatory notes – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Information from other parties or MetLife

Supporting information from other entities, third parties or MetLife, includes any information held about you, including reports, that relates to MetLife's administration of the policy/plan, including your claim. This information is required to enable MetLife to assess and manage your claim in accordance with the Terms and Conditions of your policy/group life cover.

Authority 3 explanatory notes – through this authority, you are consenting to the parties listed in the authority releasing a copy of any information they may hold about you concerning your claim, for example:

- producing a report;
- supplying MetLife with full particulars of any and all claims you have made for benefits in the event of your sickness and/or injury including copies of evidence they hold; and
- releasing your correspondence with MetLife to your accountant, financial adviser/planner, fund trustee/fund administrator, in order for them to supply MetLife with the requested particulars.

Any information released to MetLife as a result of this authority will be used to assess and manage your claim(s) with MetLife, and we will tell you each time we use your consent.

If you choose to withhold your consent to this authority, we may not be able to process your application for a claim.

A photocopy of this authority is as valid as the original.

Authority 1 - to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to **MetLife**, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form **MetLife** asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- **MetLife** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **MetLife** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Signature ▶ | Date *(dd/mm/yyyy)*

Full name (please print)

Authority 2 - to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to **MetLife**, or to third parties they engage, only if **MetLife** has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to the following:

- **MetLife** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **MetLife** is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Signature ▶ | Date *(dd/mm/yyyy)*

Full name (please print)

Authority 3 - to release other information

I authorise the parties listed below to release to **MetLife** any information held about me (including their reports) which relates to the administration of my **MetLife** policy/plan, including this claim.

- Any claims assessor, investigator, insurance reference service, credit reference service, financial institution, legal or accounting firm, auditor, employer, consultant or reinsurer.
- Any benefit provider such as other insurers or Government Departments (including Workers' Compensation, Centrelink or similar benefit providers) that provide benefits in the event of my sickness and/or injury.
- My accountant, financial adviser/planner, fund trustee/fund administrator including but not limited to providing my accountant, financial adviser/planner, fund trustee/fund administrator with copies of all correspondence (which may include personal and sensitive information) between **MetLife** and myself in respect of the claim in order for the nominated party to supply **MetLife** with the requested particulars.

I agree to the following:

- My information can be released in the form **MetLife** asks for, such as a general report, correspondence, full particulars of any and all claims I have made for benefits in the event of my sickness and/or injury including copies of evidence they hold.
- My Financial Adviser/Fund Trustee/Fund Administrator can make enquires regarding the progress of the claim for the purpose of providing me with ongoing service.
- **MetLife** can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while **MetLife** is assessing my claim or is verifying disclosures I made in connection with the cover.
- Any information released to **MetLife** under this Authority, or any previous authorities I have signed, will be used in assessing my claim(s) with **MetLife**.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Signature ▶ | Date *(dd/mm/yyyy)*

Full name (please print)

Please return the completed form to
Claims Department, MetLife Insurance Limited, GPO Box 3319, Sydney NSW 2001
or email auclaims@metlife.com

For assistance with the completion of this form, please call us on 1300 555 625
Monday to Friday 8am - 6pm AEST.

metlife.com.au

MetLife

MetLife Insurance Limited | GPO Box 3319 | Sydney NSW 2001
ABN 75 004 274 882 AFSL NO. 238 096

Tax file number declaration

Information you provide in this declaration will allow your payer to work out how much tax to withhold from payments made to you.

This is not a TFN application form.
To apply for a TFN, go to **ato.gov.au/tfn**

Terms we use

When we say:

- **payer**, we mean the business or individual making payments under the pay as you go (PAYG) withholding system.
- **payee**, we mean the individual being paid.

Who should complete this form?

You should complete this form before you start to receive payments from a new payer – for example:

- payments for work and services as an employee, company director or office holder
- payments under return-to-work schemes, labour hire arrangements or other specified payments
- benefit and compensation payments
- superannuation benefits.

You need to provide all information requested on this form. Providing the wrong information may lead to incorrect amounts of tax being withheld from payments made to you.

You do not need to complete this form if you:

- are a beneficiary wanting to provide your tax file number (TFN) to the trustee of a closely held trust. For more information, visit **ato.gov.au/trustsandtfnwithholding**
- have reached 60 years of age and started a super benefit that does not include an untaxed element for that benefit.
- are receiving superannuation benefits from a super fund and have been taken to have quoted your TFN to the trustee of the super fund.

Section A: To be completed by the payee

Question 1
What is your tax file number (TFN)?

You should give your TFN to your employer only after you start work for them. Never give your TFN in a job application or over the internet.

We and your payer are authorised by the *Taxation Administration Act 1953* to request your TFN. It's not an offence not to quote your TFN. However, quoting your TFN reduces the risk of administrative errors and having extra tax withheld. Your payer is required to withhold the top rate of tax from all payments made to you if you do not provide your TFN or claim an exemption from quoting your TFN.

How do you find your TFN?

You can find your TFN on any of the following:

- your income tax notice of assessment
- correspondence we send you
- a payment summary your payer issues to you.

If you have a tax agent, they may also be able to tell you your TFN.

If you still can't find your TFN, you can:

- phone us on **13 28 61** between 8.00am and 6.00pm, Monday to Friday
- visit your nearest shopfront (phone us on **13 28 61** to make an appointment).

If you phone or visit us we need to know we are talking to the correct person before discussing your tax affairs. We will ask you for details only you, or your authorised representative would know.

NAT 3092-07.2016

Australian Government
Australian Taxation Office

You don't have a TFN

If you don't have a TFN and want to provide a TFN to your payer, you will need to apply for one.

For more information about applying for a TFN, visit **ato.gov.au/tfn**

You may be able to claim an exemption from quoting your TFN.

Print X in the appropriate box if you:

- have lodged a TFN application form or made an enquiry to obtain your TFN. You now have 28 days to provide your TFN to your payer, who must withhold at the standard rate during this time. After 28 days, if you have not given your TFN to your payer, they will withhold the top rate of tax from future payments
- are claiming an exemption from quoting a TFN because you are under 18 years of age and do not earn enough to pay tax, or you are an applicant or recipient of certain pensions, benefits or allowances from the
  - Department of Human Services – however, you will need to quote your TFN if you receive a Newstart, Youth or sickness allowance, or an Austudy or parenting payment
  - Department of Veterans' Affairs – a service pension under the *Veterans' Entitlement Act 1986*
  - Military Rehabilitation and Compensation Commission.

Providing your TFN to your super fund

Your payer must give your TFN to the super fund they pay your contributions to. If your super fund does not have your TFN, you can provide it to them separately. This ensures:

- your super fund can accept all types of contributions to your accounts
- additional tax will not be imposed on contributions as a result of failing to provide your TFN
- you can trace different super accounts in your name.

For more information about providing your TFN to your super fund, visit **ato.gov.au/supereligibility**

Question 2–5

Complete with your personal information.

Question 6
On what basis are you paid?

Check with your payer if you are not sure.

Question 7
Are you an Australian resident for tax purposes?

Generally, we consider you to be an Australian resident for tax purposes if you:

- have always lived in Australia or you have come to Australia and now live here permanently
- are an overseas student doing a course that takes more than six months to complete
- migrate to Australia and intend to reside here permanently.

If you go overseas temporarily and do not set up a permanent home in another country, you may continue to be treated as an Australian resident for tax purposes.

Foreign resident tax rates are different

A higher rate of tax applies to a foreign resident's taxable income and foreign residents are not entitled to a tax-free threshold nor can they claim tax offsets to reduce withholding, unless you are in receipt of an Australian Government pension or allowance.

To check your Australian residency status for tax purposes or for more information, visit **ato.gov.au/residency**

Answer **no** to this question if you are not an Australian resident for tax purposes, unless you are in receipt of an Australian Government pension or allowance. If you answer **no**, you must also answer **no** at question 10.

Question 8
Do you want to claim the tax-free threshold from this payer?

The tax-free threshold is the amount of income you can earn each financial year that is not taxed. By claiming the threshold, you reduce the amount of tax that is withheld from your pay during the year.

Answer **yes** if you want to claim the tax-free threshold, you are an Australian resident for tax purposes, and one of the following applies:

- you are not currently claiming the tax-free threshold from another payer
- you are currently claiming the tax-free threshold from another payer and your total income from all sources will be less than the tax-free threshold.

Answer **yes** if you are a foreign resident in receipt of an Australian Government pension or allowance.

Otherwise answer **no**.

If you receive any taxable government payments or allowances, such as Newstart, Youth Allowance or Austudy payment, you are likely to be already claiming the tax-free threshold from that payment.

For more information about the current tax-free threshold, which payer you should claim it from, or how to vary your withholding rate, visit **ato.gov.au/taxfreethreshold**

Question 9
Do you want to claim the seniors and pensioners tax offset by reducing the amount withheld from payments made to you?

Claim tax offsets with only one payer

You are not entitled to reduce your withholding amounts, or claim the seniors and pensioners tax offset (SAPTO), with more than one payer at the same time.

If you receive income from more than one source and need help with this question, phone **1300 360 221** between 8.00am and 6.00pm, Monday to Friday.

How your income affects the amount of your tax offset

You must meet the eligibility conditions to receive SAPTO. Your rebate income, not your taxable income, determines the amount of SAPTO, if any, you will receive.

Answer **yes** if you are eligible and choose to claim SAPTO with this payer. To reduce the amount withheld from payments you receive during the year from this payer, you will also need to complete a *Withholding declaration* (NAT 3093).

Answer **no** if one of the following applies:

- you are not eligible for SAPTO
- you are already claiming SAPTO with another payer
- you are eligible but want to claim your entitlement to the tax offset as a lump sum in your end-of-year income tax assessment.

For more information about your eligibility to claim the tax offset or rebate income, visit **ato.gov.au/taxoffsets**

Question 10
Do you want to claim a zone, overseas forces or invalid and invalid carer tax offset by reducing the amount withheld from payments made to you?

Claim tax offsets with only one payer

You are not entitled to claim tax offsets with more than one payer at the same time.

You may be eligible for one or more of the following:

- a zone tax offset if you live or work in certain remote or isolated areas of Australia
- an overseas forces tax offset if you serve overseas as a member of Australia's Defence Force or a United Nations armed force
- an invalid and invalid carer tax offset.

Answer **yes** to this question if you are eligible and choose to receive tax offsets by reducing the amount withheld from payments made to you from this payer. You also need to complete a *Withholding declaration* (NAT 3093).

Answer **no** to this question if you are either:

- not eligible for the tax offsets
- a foreign resident
- choose to receive any of these tax offsets as an end-of-year lump sum through the tax system
- are already claiming the offset from another payer.

For more information about your entitlement, visit **ato.gov.au/taxoffsets**

Question 11
(a) Do you have a Higher Education Loan Program (HELP), Student Start-up Loan (SSL) or Trade Support Loan (TSL) debt?

Answer **yes** if you have a HELP, SSL or TSL debt.

Answer **no** if you do not have a HELP, SSL or TSL debt, or you have repaid your debt in full.

You have a HELP debt if either:

- the Australian Government lent you money under HECS-HELP, FEE-HELP, OS-HELP, VET FEE-HELP or SA-HELP.
- you have a debt from the previous Higher Education Contribution Scheme (HECS).

(b) Do you have a Financial Supplement debt?

Answer **yes** if you have a Financial Supplement debt.

Answer **no** if you do not have a Financial Supplement debt, or you have repaid your debt in full.

For information about repaying your HELP, SSL, TSL or Financial Supplement debt, visit **ato.gov.au/getloaninfo**

Have you repaid your HELP, SSL, TSL or Financial Supplement debt?

When you have repaid your HELP, SSL, TSL or Financial Supplement debt, you need to complete a *Withholding declaration* (NAT 3093) notifying your payer of the change in your circumstances.

Sign and date the declaration

Make sure you have answered all the questions in section A, then sign and date the declaration. Give your completed declaration to your payer to complete section B.

Section B: To be completed by the payer

Important information for payers – see the reverse side of the form.

Lodge online

Payers can lodge TFN declaration reports online if you have software that complies with our specifications.

For more information about lodging the TFN declaration report online, visit **ato.gov.au/lodgetfndeclaration**

More information

Internet

- For general information about TFNs, tax and super in Australia, including how to deal with us online, visit our website at **ato.gov.au**
- For information about applying for a TFN on the web, visit our website at **ato.gov.au/tfn**
- For information about your super, visit our website at **ato.gov.au/superseeker**

Useful products

In addition to this TFN declaration, you may also need to complete and give your payer the following forms which you can download from our website at **ato.gov.au**:

- *Withholding declaration* (NAT 3093) if you want to
  - claim entitlement to the seniors and pensioners tax offset (question 9) or other tax offsets (question 10)
  - change information you previously provided in a TFN declaration.
- *Medicare levy variation declaration* (NAT 0929) if you qualify for a reduced rate of Medicare levy or are liable for the Medicare levy surcharge. You can vary the amount your payer withholds from your payments.
- *Standard choice form* (NAT 13080) to choose a super fund for your employer to pay super contributions to. You can find information about your current super accounts and transfer any unnecessary super accounts through myGov after you have linked to the ATO. Temporary residents should visit **ato.gov.au/departaustralia** for more information about super.

Other forms and publications are also available from our website at **ato.gov.au/onlineordering** or by phoning **1300 720 092**.

Phone

- Payee – for more information, phone **13 28 61** between 8.00am and 6.00pm, Monday to Friday. If you want to vary your rate of withholding, phone **1300 360 221** between 8.00am and 6.00pm, Monday to Friday.
- Payer – for more information, phone **13 28 66** between 8.00am and 6.00pm, Monday to Friday.

If you phone, we need to know we're talking to the right person before we can discuss your tax affairs. We'll ask for details only you, or someone you've authorised, would know. An authorised contact is someone you've previously told us can act on your behalf.

If you do not speak English well and need help from the ATO, phone the Translating and Interpreting Service on **13 14 50**.

If you are deaf, or have a hearing or speech impairment, phone the ATO through the National Relay Service (NRS) on the numbers listed below:

- TTY users – phone **13 36 77** and ask for the ATO number you need (if you are calling from overseas, phone **+61 7 3815 7799**)
- Speak and Listen (speech-to-speech relay) users – phone **1300 555 727** and ask for the ATO number you need (if you are calling from overseas, phone **+61 7 3815 8000**)
- Internet relay users – connect to the NRS on **relayservice.gov.au** and ask for the ATO number you need.

If you would like further information about the National Relay Service, phone **1800 555 660** or email **helpdesk@relayservice.com.au**

Privacy of information

Taxation law authorises the ATO to collect information and to disclose it to other government agencies. For information about your privacy, go to **ato.gov.au/privacy**

Our commitment to you

We are committed to providing you with accurate, consistent and clear information to help you understand your rights and entitlements and meet your obligations.

If you follow our information in this publication and it turns out to be incorrect, or it is misleading and you make a mistake as a result, we must still apply the law correctly. If that means you owe us money, we must ask you to pay it but we will not charge you a penalty. Also, if you acted reasonably and in good faith we will not charge you interest.

If you make an honest mistake in trying to follow our information in this publication and you owe us money as a result, we will not charge you a penalty. However, we will ask you to pay the money, and we may also charge you interest. If correcting the mistake means we owe you money, we will pay it to you. We will also pay you any interest you are entitled to.

If you feel that this publication does not fully cover your circumstances, or you are unsure how it applies to you, you can seek further assistance from us.

We regularly revise our publications to take account of any changes to the law, so make sure that you have the latest information. If you are unsure, you can check for more recent information on our website at **ato.gov.au** or contact us.

This publication was current at **July 2016**.

Published by

Australian Taxation Office
Canberra
July 2016

JS 35902

Australian Government
Australian Taxation Office

Tax file number declaration

This declaration is NOT an application for a tax file number.

- Use a black or blue pen and print clearly in BLOCK LETTERS.
- Print **X** in the appropriate boxes.
- Read all the instructions including the privacy statement before you complete this declaration.

ato.gov.au

Section A: **To be completed by the PAYEE**

1 What is your tax file number (TFN)?

For more information, see question 1 on page 2 of the instructions.

OR I have made a separate application/enquiry to the ATO for a new or existing TFN.

OR I am claiming an exemption because I am under 18 years of age and do not earn enough to pay tax.

OR I am claiming an exemption because I am in receipt of a pension, benefit or allowance.

2 What is your name? Title: Mr Mrs Miss Ms

Surname or family name

First given name

Other given names

3 If you have changed your name since you last dealt with the ATO, provide your previous family name.

4 What is your date of birth? Day / Month / Year

5 What is your home address in Australia?

Suburb/town/locality

State/territory Postcode

6 On what basis are you paid? (Select only one.)

Full-time employment | Part-time employment | Labour hire | Superannuation or annuity income stream | Casual employment

7 Are you an Australian resident for tax purposes? (Visit **ato.gov.au/residency** to check) **Yes** **No**

8 Do you want to claim the tax-free threshold from this payer?

Only claim the tax-free threshold from one payer at a time, unless your total income from all sources for the financial year will be less than the tax-free threshold.

Yes **No** Answer **no** here and at question 10 if you are a foreign resident, except if you are a foreign resident in receipt of an Australian Government pension or allowance.

9 Do you want to claim the seniors and pensioners tax offset by reducing the amount withheld from payments made to you?

Yes Complete a *Withholding declaration* (NAT 3093), but only if you are claiming the tax-free threshold from this payer. If you have more than one payer, see page 3 of the instructions. **No**

10 Do you want to claim a zone, overseas forces or invalid and invalid carer tax offset by reducing the amount withheld from payments made to you?

Yes Complete a *Withholding declaration* (NAT 3093). **No**

11 (a) Do you have a Higher Education Loan Program (HELP), Student Start-up Loan (SSL) or Trade Support Loan (TSL) debt?

Yes Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment. **No**

(b) Do you have a Financial Supplement debt?

Yes Your payer will withhold additional amounts to cover any compulsory repayment that may be raised on your notice of assessment. **No**

DECLARATION by payee: *I declare that the information I have given is true and correct.*

Signature

You MUST SIGN here

Date Day / Month / Year

There are penalties for deliberately making a false or misleading statement.

Once section A is completed and signed, give it to your payer to complete section B.

Section B: **To be completed by the PAYER** (if you are not lodging online)

1 What is your Australian business number (ABN) or withholding payer number? Branch number (if applicable)

2 If you don't have an ABN or withholding payer number, have you applied for one?

Yes **No**

3 What is your legal name or registered business name (or your individual name if not in business)?

DECLARATION by payer: *I declare that the information I have given is true and correct.*

Signature of payer

Date Day / Month / Year

There are penalties for deliberately making a false or misleading statement.

4 What is your business address?

Suburb/town/locality

State/territory Postcode

5 Who is your contact person?

Business phone number

6 If you no longer make payments to this payee, print X in this box.

Return the completed original ATO copy to:
Australian Taxation Office
PO Box 9004
PENRITH NSW 2740

IMPORTANT
See next page for:
- payer obligations
- lodging online.

Sensitive (when completed)

30920716

Payer information

The following information will help you comply with your pay as you go (PAYG) withholding obligations.

Is your employee entitled to work in Australia?

It is a criminal offence to knowingly or recklessly allow someone to work, or to refer someone for work, where that person is from overseas and is either in Australia illegally or is working in breach of their visa conditions.

People or companies convicted of these offences may face fines and/or imprisonment. To avoid penalties, ensure your prospective employee has a valid visa to work in Australia before you employ them. For more information and to check a visa holder's status online, visit the Department of Immigration and Border Protection website at **immi.gov.au**

Payer obligations

If you withhold amounts from payments, or are likely to withhold amounts, the payee may give you this form with section A completed. A TFN declaration applies to payments made after the declaration is provided to you. The information provided on this form is used to determine the amount of tax to be withheld from payments based on the PAYG withholding tax tables we publish. If the payee gives you another declaration, it overrides any previous declarations.

Has your payee advised you that they have applied for a TFN, or enquired about their existing TFN?

Where the payee indicates at question 1 on this form that they have applied for an individual TFN, or enquired about their existing TFN, they have 28 days to give you their TFN. **You must withhold tax for 28 days at the standard rate according to the PAYG withholding tax tables.** After 28 days, if the payee has not given you their TFN, you must then withhold the top rate of tax from future payments, unless we tell you not to.

If your payee has not given you a completed form you must:

- notify us within 14 days of the start of the withholding obligation by completing as much of the payee section of the form as you can. Print 'PAYER' in the payee declaration and lodge the form – see 'Lodging the form'.
- withhold the top rate of tax from any payment to that payee.

For a full list of tax tables, visit our website at **ato.gov.au/taxtables**

Lodging the form

You need to lodge TFN declarations with us within 14 days after the form is either signed by the payee or completed by you (if not provided by the payee). **You need to retain a copy of the form for your records.** For information about storage and disposal, see below.

You may lodge the information:

- **online** – lodge your TFN declaration reports using software that complies with our specifications. There is no need to complete section B of each form as the payer information is supplied by your software.
- **by paper** – complete section B and send the original to us within 14 days.

For more information about lodging your TFN declaration report online, visit our website at **ato.gov.au/lodgetfndeclaration**

Provision of payee's TFN to the payee's super fund

If you make a super contribution for your payee, you need to give your payee's TFN to their super fund on the day of contribution, or if the payee has not yet quoted their TFN, within 14 days of receiving this form from your payee.

Storing and disposing of TFN declarations

The TFN guidelines issued under the *Privacy Act 1988* require you to use secure methods when storing and disposing of TFN information. You may store a paper copy of the signed form or electronic files of scanned forms. Scanned forms must be clear and not altered in any way.

If a payee:

- submits a new *TFN declaration* (NAT 3092), you must retain a copy of the earlier form for the current and following financial year.
- has not received payments from you for 12 months, you must retain a copy of the last completed form for the current and following financial year.

Penalties

You may incur a penalty if you do not:

- lodge TFN declarations with us
- keep a copy of completed TFN declarations for your records
- provide the payee's TFN to their super fund where the payee quoted their TFN to you.

EFT payment instructions

Provide your bank or credit union details below.

1. Your details

Title ☐ Mr ☐ Ms ☐ Mrs ☐ Other _____ Member number _____

Your name _____

2. Your bank details

BSB _____ – _____

Account number _____

Account name _____

an account in your name or a joint account where you are one of the account holders

Name of bank/ credit union _____

3. Authorisation

I authorise Mercer as administrator of ElectricSuper to credit my salary continuance insurance benefit payments to my bank/ credit union account above.

Signature _____ Date _____ / _____ / _____

06. To Be Completed Only If Claiming for Loss of Income

We are unable to process benefit payments without confirmation of income

1. If self employed please indicate by ticking the box ☐ Confirmation of earnings MUST be submitted with claim form (i.e. Income Tax Return & Profit/Loss Statement)

2. -If employed as a wage earner the following is to be completed by your employer (or attach pay slip).

I hereby certify that _____ has been unable to attend his/her usual occupation with the company as a result of an

Injury / Illness suffered whilst _____ on the ____ ____ ____ ____

He/She has been incapacitated since ____ ____ ____ ____ ____ ____ ____ ____ and is expected to/did resume duties on ____ ____ ____ ____ ____ ____ ____ ____

His/Her Gross Salary, exclusive of bonuses, commission, allowances etc. at the Date of Injury was $ _____ per week

During the period of incapacity he/she received $ _____ from ____ ____ ____ ____ ____ ____ ____ ____ to ____ ____ ____ ____ ____ ____ ____ ____

Please specify type of pay _____

(If there is insufficient room to specify pay types, please provide pay history copies or print-outs)

Name of Company _____ Has been employed since ____ ____ ____ ____ ____ ____ ____ ____

Address _____

Signature of Supervisor or Paymaster _____ Date ____ ____ ____ ____ ____ ____ ____ ____

Name (Please Print) _____ Telephone Number _____

07. Declaration

Compulsory

General Insurance Code of Practice
AHI proudly support the General Insurance Code of Practice (the 'Code'). The purpose of the Code is to raise the standards of practice and service in the general insurance industry. For further information on the Code, please visit www.codeofpractice.com.au.

Complaints and Disputes Resolution
If you have a dispute and after talking to AHI, you are still dissatisfied and you wish to take the matter further we have a Complaints and Dispute Resolution Procedure which undertakes to provide an answer to your concerns within 15 business days in accordance with the General Insurance Code of Practice. If you still remain dissatisfied after proceeding with the above, our process includes advising you on how to contact the insurance industry's external independent complaints scheme, the Australian Financial Complaints Authority (AFCA). Access to this scheme is free of charge to you.

Privacy Declaration
I/We agree that, by submitting this form, the personal information I/we provide to AHI in this form or otherwise may be collected, held, used and disclosed in the manner set out in the AHI Privacy Policy found at www.ahiinsurance.com.au, including for the processing of this claim.

By signing and dating the form above or returning this form electronically, once completed, you declare the following:

Declaration:
I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

Authority
I authorise any hospital and/or physician who has treated me to provide AHI with copies of medical records or of my past medical history, as requested.

Signature of Claimant _____

Date ____ ____ ____ ____ ____ ____ ____ ____

Signature of the Insured (if other than claimant) _____

Date ____ ____ ____ ____ ____ ____ ____ ____

Medical Statement General

Please note: This form needs to be completed by a registered medical practitioner. Any costs associated with the completion of this form is the responsibility of the patient.

The information provided in this form will be used to assist in determining all potential benefit entitlements available for your patient.

Please provide all details you have available as this can assist in minimising the need for further information requests to allow a faster outcome for your patient.

Privacy - Use and disclosure of personal information

Your privacy with MetLife Insurance Limited ABN 75 004 274 882 AFSL 238096 ('MetLife' or the 'Insurer')

The personal information you provide in the form is necessary for MetLife to provide your patient with the products and services they have requested from MetLife, and to manage their claim. You do not have to provide MetLife with this personal information, but if you do not do so MetLife may not be able to provide your patient with the products or services. MetLife complies with the Privacy Act 1988 and the principles laid out in its Privacy policy which details information about the entities that MetLife usually discloses personal information to (including overseas recipients), how you may access or seek correction of personal information, how we manage that information and our complaints process. MetLife's Privacy Policy is readily available and can be viewed at www.metlife.com.au/privacy.

Section 1. Medical practitioner details

Title	Given name(s)	Surname

Address

Suburb	State	Postcode

Phone number	Qualifications

Signature	Date *(dd/mm/yyyy)*
▶	

Section 2. Patient/claimant details

Title	Given name(s)

Surname	Date of birth *(dd/mm/yyyy)*

Section 3. Patient history

1. Are you the patient's usual doctor? ☐ Yes ☐ No	If Yes, how long have you known the patient?

2. When did the patient first consult you for the present condition (*dd/mm/yyyy*)?	/ /
3. When did the present condition commence (*dd/mm/yyyy*)?	/ /
4. From what date do you believe the patients condition to have prevented your patient from working (*dd/mm/yyyy*)?	/ /
5. Please confirm the total number of consults you have completed with this patient in relation to this condition:	

Section 3. Patient history (continued)

6. Is this your patient's first episode of this condition? ☐ Yes ☐ No

If No, please provide copies of relevant reports or records:

7. Please detail the patient's current condition including cause, symptoms, your current diagnosis and the objective evidence relied on to reach this opinion. Please include copies of any evidence available and copies of any imaging performed.

8. Please provide details of other medical and allied health practitioners the patient has consulted for this condition.
Alternatively, you can provide copies of any referral letters or reports from other medical and allied health professionals in lieu of completing the below.

Name and specialisation	Address and phone number	Date range of consults	
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

9. Please detail the current treatment plan including SMART (Specific, Measurable, Achievable, Realistic, Timely) goals and progress achieved so far:

Treatment	Goals	Progress achieved so far

10. Please provide a summary of all previous treatment provided including outcomes achieved:

11. Is any additional treatment planned in the future (e.g. surgery)? ☐ Yes ☐ No

If Yes, please provide further detail including what might trigger referral for additional treatment, expected outcome and timeframes:

Section 3. Patient history (continued)

12. If your patient is not currently consulting any allied health practitioners, do you believe this would be beneficial to help with functional recovery and management of symptoms? ☐ Yes ☐ No

If Yes, provide recommended speciality below:
If No, provide further detail below:

13. Have there been any barriers to participation in the recommended treatment plan? ☐ Yes ☐ No

If Yes, please indicate what these barriers are below.

☐ Financial ☐ Logistical e.g. transport ☐ Availability e.g. waiting lists

☐ Other (specify details)

14. Are you aware of any social or psychological factors that could impact your patient's recovery and overall wellbeing? ☐ Yes ☐ No

If Yes, please provide further details:

Section 4. Medical certification

15. Please summarise your understanding of your patient's occupation, including core duties:
e.g. Office Manager:
- *Sedentary physical demand level.*
- *Sits at an office desk or in meeting with staff frequently.*
- *Stands and walks about the office frequently.*
- *Repetitive movements of the hands and fingers when operating a keyboard and mouse, phones and writing instruments.*
- *Mental skills necessary include a high level of cognitive functioning with communication, listening, administrative, organisational, financial and budgeting, problem-solving, planning and decision-making capabilities.*

Section 4. Medical certification (continued)

16. If your patient is currently unable to work, or able to work on a restricted basis, please complete the following table with regards to your patient's functional tolerances:

a) Sitting	☐ Over 2 hours	☐ Up to 2 hours	☐ Up to 60 minutes	☐ Up to 30 minutes	☐ Up to 10 minutes	☐ Unable/ limited
Additional comments:						
b) Standing	☐ Over 2 hours	☐ 2 hours	☐ 60 minutes	☐ 30 minutes	☐ 10 minutes	☐ Unable/ limited
Additional comments:						
c) Walking	☐ Over 2 hours	☐ 2 hours	☐ 60 minutes	☐ 30 minutes	☐ 10 minutes	☐ Unable/ limited
Additional comments:						
d) Lifting (consider relevance to injury e.g. position, one or two hands)	☐ Over 20kg	☐ Up to 20kg	☐ Up to 15kg	☐ Up to 10kg	☐ Up to 5kg	☐ Minimal (1 - 2kg)
Additional comments:						
e) Driving	☐ Over 2 hours	☐ 2 hours	☐ 60 minutes	☐ 30 minutes	☐ 10 minutes	☐ Unable
Additional comments:						
f) Travelling by other means e.g. public transport						
g) Pushing/pulling						
h) Bending/twisting/ squatting						
i) Reaching						
j) Fine motor e.g. computer use, gripping						
k) Other (please specify)						

Section 4. Medical certification (continued)

Psychological function

Functional ability	Has this been impacted?	If Yes, please describe the impact:
a) Concentration	☐ Yes ☐ No	
b) Memory	☐ Yes ☐ No	
c) Energy levels	☐ Yes ☐ No	
d) Sleep	☐ Yes ☐ No	
e) Social interaction	☐ Yes ☐ No	
f) Motivation	☐ Yes ☐ No	
g) Mood	☐ Yes ☐ No	
h) Self-care	☐ Yes ☐ No	
i) Emotional regulation	☐ Yes ☐ No	
j) Other (please specify)	☐ Yes ☐ No	

17. Could work capacity be enhanced by modifications and/or equipment (e.g. working from home, sit to stand desk, providing transport to and from office)? ☐ Yes ☐ No

If Yes, please provide further detail below:

18. What do you see as being the key factors limiting recovery and return to work (e.g. difficulty managing symptoms, uncontrolled flare-ups)?

Section 5. Certification - Inability to work

19. What period was the patient totally unable to perform any of the duties of his/her occupation (*dd/mm/yyyy*)?

Period from / / to / /

20. When do you consider that the patient may return to work on a partial/restricted or pre-disability basis (*dd/mm/yyyy*)? / /

21. Basis of return to work ☐ Restricted duties ☐ Pre-disability duties ☐ Restricted hours ☐ Pre-disability hours

Hours of work per day?

Days of work per week?

22. Please detail any restricted duties not captured in Section 4. Medical certification.

Section 5. Certification - Inability to work (continued)

23. Do you believe your patient may be fit to return to work in an alternate occupation or employment within their current education, training or experience? ☐ Yes ☐ No

If No, provide details in relation to why they may not be fit to return:
If Yes, provide details in relation to alternate employment options you believe may be suitable:

Section 6. Other information

24. Are you completing claim forms on behalf of the patient for any other company in respect of this condition? ☐ Yes ☐ No

If Yes, please provide details:

25. In your medical opinion, what is your patient's estimated life expectancy inclusive of all reasonable treatment options?
Skip if not applicable to your patient's condition.

☐ < 12 months ☐ 24 to 36 months ☐ N/A

☐ 12 to 24 months ☐ > 36 months

Additional comments

Please use this space if required.

Please attach copies of any medical reports, medical certificates or test results you may have in your possession and return the completed form to
Claims Department, MetLife Insurance Limited, GPO Box 3319, Sydney NSW 2001
or email auclaims@metlife.com

For assistance with the completion of this form, please call us on 1300 555 625
Monday to Friday 8am - 6pm AEST.

metlife.com.au

MetLife

MetLife Insurance Limited | GPO Box 3319 | Sydney NSW 2001
ABN 75 004 274 882 AFSL NO. 238 096

Personal Accident & Sickness Claim Form – Employer Statement		
Policy Number	0029326	
Insurer	Accident & Health International Underwriting Pty Ltd	
Employee's Surname		
Employee's Given name(s)		
Employee's Date Of Birth		
Employment Date with SAPN		
First date of absence due to this Illness / Injury		
Sick Leave entitlement as at first date of absence from this Injury or Illness		Days
Date sick leave expires		/ /
Date employment ceased with SAPN (if applicable)		/ /
Reason for cessation of employment (if applicable)		
His / Her wage/salary, overtime, allowances and corporate performance bonuses (and the cash equivalent of additional benefits e.g. car included within TEC employment packages) for the previous 12-month period, divided by 52 is…… Salary without bonuses or overtime for past 12months.		$_____ per week $_____ per week
Is the employee eligible to lodge a claim under the ElectricSuper?		
If yes to above, what ElectricSuper Category is the employee in?		
Is the employee eligible to Claim under Workers Compensation?		
If the employee is eligible to Claim under Workers Compensation has a claim been lodged?		
Name	**Robert McKinnon** **Workplace Relations Advisor**	
TELEPHONE NUMBER	**0488 582 151**	
DATED	**/ /2021**	
SIGNATURE		

Employer's Statement

Privacy - Use and disclosure of personal information

Your privacy with MetLife Insurance Limited ABN 75 004 274 882 AFSL 238096 ('MetLife' or the 'Insurer')

The personal information you provide in the form is necessary for MetLife to provide your employee with the products and services they have requested from MetLife, and to manage their claim. You do not have to provide MetLife with this personal information, but if you do not do so MetLife may not be able to provide your employee with the products or services. MetLife complies with the Privacy Act 1988 and the principles laid out in its Privacy policy which details information about the entities that MetLife usually discloses personal information to (including overseas recipients), how you may access or seek correction of personal information, how we manage that information and our complaints process. MetLife's Privacy Policy is readily available and can be viewed at www.metlife.com.au/privacy.

Section 1. Employee details

Title	Given name(s)

Surname	Date of birth *(dd/mm/yyyy)*

Date joined company *(dd/mm/yyyy)*	Date joined plan *(dd/mm/yyyy)*

Annual salary at the date last worked (excluding overtime, bonus allowances etc. Please provide copies of pay slips in support of your employee's annual salary)	$

Section 2. Occupation details

1. What is the most recent role the employee held with the company? Please attach a copy of your employee's role description.

Job title	Full-time/ Part-time/Casual/ Contract/ Self-employed	Duties	Period employed

Please provide a copy of the employment history with your business for the named employee. Including role title, period employed in role, reason for changing role and duties of role.

2. Date these were last performed	/ /

3. Hours of work from to	4. No. of days per week

5. Please list below any machines or special equipment used and whether they were operated manually or automatically.

Machine/equipment	Manual	Automatic
	☐	☐
	☐	☐

6. Was the employee employed in a supervisory capacity? ☐ Yes ☐ No	If Yes, how many staff did the employee supervise?

Section 2. Occupation details (continued)

7. In what area did they work (e.g. office/loading dock etc.)?

8. Please confirm the physical requirement of the role where applicable by completing the following.

Percentage of time spent in task				Percentage of time spent in task	
Task	**<30%**	**31-70%**	**>70%**	**Task**	**% per day**
Lifting, 20kg & over				Walking	
Lifting, 7 - 19kg				Standing	
Lifting, under 7kg				Climbing – ladders, scaffolding etc.	
Carrying, 20kg & over				Crawling	
Carrying, 7 - 19kg				Kneeling	
Carrying, under 7kg				Climbing – ramps, steps etc.	
Reaching above shoulders				Sitting	

9. What qualifications, training and experience does the employee have?

10. Are there any alternative roles available or could the employee's skills be used in any other capacity within the company? ☐ Yes ☐ No

If Yes, what similar roles is the employee skilled to perform?

11. Was the employee on any restricted/partial duties prior to the date they ceased work? ☐ Yes ☐ No

If Yes, please provide details.

12. Date restricted/partial duties commenced *(dd/mm/yyyy)*. / /

If Yes, please provide details.

Section 3. Claim details

13. Has the employee resigned from employment?

☐ Yes ☐ No

If Yes, please provide the date of resignation *(dd/mm/yyyy)*.

/ /

14. Were you notified that the employee was certified unfit prior to the employee ceasing work? ☐ Yes ☐ No

15. What reason was provided when the employee ceased work?

16. Has any supported return to work plan been attempted? ☐ Yes ☐ No

If Yes, please provide details including name of provider, roles undertaken and period of rehabilitation (please attach a separate list if insufficient space).

Provider	Roles undertaken	Period of rehabilitation

17. Please provide details of all leave taken in the 12 months prior to the employee ceasing work.
Note: You do not need to complete this question if you are providing leave history reports.

Sick leave - period(s)	
Annual leave - period(s)	
Other leave - period(s)	

18. Please provide details of any money paid to the employee since they ceased work (e.g. superannuation, Workers' Compensation, sick leave, annual leave etc.)?

Type of payment	Period of payment	Amount

19. Are you aware of any other claim including work cover, total and permanent disablement, income cover, etc? ☐ Yes ☐ No

If Yes, please provide details including name and address of insurer.

Insurer	Contact name and number	Claim number

Section 4. Other comments

Section 5. Declaration

I hereby declare that to the best of my knowledge the information stated above is correct.

Employer signature

Date *(dd/mm/yyyy)*

Title

Given name(s)

Surname

Job title

Employer name

Employer address

Suburb

State

Postcode

Phone no.

Fax no.

Email

Please return the completed form to
Claims Department, MetLife Insurance Limited, GPO Box 3319, Sydney NSW 2001
or email auclaims@metlife.com

For assistance with the completion of this form, please call us on 1300 555 625
Monday to Friday 8am - 6pm AEST.

metlife.com.au

MetLife Insurance Limited | GPO Box 3319 | Sydney NSW 2001
ABN 75 004 274 882 AFSL NO. 238 096