Section C: Employer's Statement

Section C is to be completed by the Employer.

1. Employer Details

Name of employer:

Project:

Employer number:

Contact person:

Phone:

Email:

Employee's name that is making the claim:

Employee's payroll number:

The employee has been:

☐ totally incapacitated since:

or;

☐ partially incapacitated since:

and

☐ is due to return to work on:

or;

☐ did return to work on:

To your knowledge is your employee receiving any benefits from workers compensation or another insurance provider as a result of this injury or sickness? Yes ☐ No ☐

If Yes, please provide details below.

Claim/policy number:

Name of insurer:

Contact name:

Contact number:

This employee has been employed on the following basis:

☐ full time ☐ part time ☐ casual ☐ contractor

Date employment commenced (DD/MM/YY):

Please confirm employees current work status:

☐ still employed ☐ terminated on (DD/MM/YY): ☐ contract end date (DD/MM/YY):

2. Payment Directions

In the event that the employee is entitled to benefits, those benefits will be paid directly to the employee into their nominated account.

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You can read more about how we collect, use and disclose your personal information through requesting a copy of our Privacy Policy from our privacy officer on **02 9376 7888** or accessing our website at **uplus.com.au**.

Please attach a 26 week pay report substantiating the employees average weekly earnings (including any payments paid since incapacity).

Please attach a copy of the employee's job description and any termination documentation (if applicable).

Declaration

I hereby declare that this condition:

☐ is work-related

☐ is non work-related

I hereby declare that this condition:

☐ is covered by workers compensation

☐ is not covered by workers compensation

I hereby declare we are:

☐ prepared ☐ not prepared to provide ☐ suitable duties ☐ restricted duties

in the event of a non-work related condition.

Signature

Name:

Position held:

Date: