

employer statement (income protection and/or total and permanent disablement claim)

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Important: Please make sure you've answered all questions.

If all questions are not answered, your employee's application may be delayed as the form may be returned.

Please use **BLOCK** letters and dark ink when completing this form and ensure it's signed and dated.

SECTION A: Employee Details

Given names

Surname

Date of birth

Employer details

Company name

ABN

Phone/Email

SECTION B: Employment

1. What is the employee's usual job title?

2. Please outline the important duties and tasks for this role.

3. What percentage of the employee's occupation was spent on the following? (Note: Total should equal 100%)

Walking % of the day Standing % of the day Crawling % of the day
Kneeling % of the day Sitting % of the day

4. Did the employee's occupation involve physical activity? Yes No

If 'Yes', please complete the below:

Lifting and carrying 20 kg and over %

Lifting and carrying 5–19kg %

Lifting and carrying under 5 kg %

5. What is the commencement date of the employee's role they were performing prior to ceasing work? (dd/mm/yyyy)

6. Employment terms: Permanent full-time Permanent part-time Casual Contract

7. What is the employee's gross annual salary?

8. What were the average days and hours the employee worked per week prior to ceasing work?

 days per week AND hours per week

9. If working hours vary, what were the average hours the employee worked per week over the 12 months prior to ceasing work?

10. From the time the employee commenced employment until they ceased, were they working their full and normal duties of the role, without any restrictions?

Yes No

If 'No', please provide details of restrictions and when they commenced and ceased.

SECTION C: Work Duties

11. What date did the employee physically cease working? (dd/mm/yyyy)

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12. Why did the employee cease work?

13. Since ceasing work, has the employee returned to work, or are they expected to return to work in any capacity at all? Yes No

If 'Yes', date returned (dd/mm/yyyy):

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In what capacity has the employee returned to work?

If 'No', expected return to work date (dd/mm/yyyy):

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14. Was the employee's employment terminated? Yes No

If 'Yes', please provide reason for termination and their termination date:

SECTION D: Leave and Benefit Details

15. Has the employee claimed workers' compensation? Yes No

If 'Yes', please provide the following information:

Name of Insurer:

Workers' compensation claim number:

16. Has there been any period of sick and/or annual leave paid out over the period of incapacity? Yes No

If 'Yes', please provide dates of any sick and/or annual leave taken:

17. Please attach the following documents where available:

- Job description
- Workplace rehabilitation plan
- Pay and sick leave records for the 12 months prior to the employee ceasing work
- Copy of last group certificate

Declaration

Please provide your details below and we thank you for completing this form.

I am authorised to answer the above questions on behalf of the employer named above and declare that the above statements are true, correct, and complete. I can confirm I have handled, collected, used, and disclosed the personal and sensitive information provided with this form in accordance with privacy law.

Name

Job title

Email

Telephone

Fax

Signature

Date