## 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:			
$\square$ totally incapacitated since:		$\hfill\Box$ is due to return to work	on:
or;	ar	nd or;	
☐ partially incapacitated since:		☐ did return to work on:	
To your knowledge is your employee re provider as a result of this injury or sick		ompensation or another insurance	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 ☐ casua	•		
Date employment commenced (DD/Mi			
Please confirm employees current work	k status:		
□ still employed □ terminated on (DD/MM/YY): □ □ contract end date (DD/MM/YY): □			
2. Payment Directions			
In the event that the employee is entitle	ed to benefits, those benefits will be p	paid directly to the employee into their	nominated account.
Privacy Statement		Declaration	
We are subject to the Australian Privacy Principles as per the <i>Privacy Act</i> 1988 (Cth) (the Act). We collect your personal information to enable us to		I hereby declare that this condition:	
provide, offer and administer our product	s and services or otherwise as	<ul><li>☐ is work-related</li><li>☐ is non work-related</li></ul>	
permitted by law. Reasons for collection include, but are not limited to, responding to your enquiries, providing you with assistance you request us, maintaining and administering our products and services (for example processing requests for quotes, applications for insurance, offering insurance terms and any other purpose identified at the time of collecting your information). We may be required to disclose your information to third parties to assist with your insurance needs (this can include disclosure to an overseas insurer such as Lloyd's of London or reinsurer).  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.		I hereby declare that this condition:  ☐ is covered by workers compensation ☐ is not covered by workers compensity	
		I hereby declare we are:	
		☐ prepared to provide ☐ not prepared in the event of a non-work related con	☐ suitable duties ☐ restricted duties
		Signature	andon.
3 22 22. 2 . 300 or accooning our	at apresented.		
Please attach a 26 week pay report substantiating the employees average weekly earnings (including any		Name:	
payments paid since incapa	acity).		
Please attach a copy of the and any termination docum	employee's job description entation (if applicable).	Position held:	Date:

Please ensure Sections A, B & C have been completed. Details on returning your form can be found on page 1.

