



Risk Only Super Solution (ROSS) Employer Statement Death Claim

STATEMENT BY EMPLOYER. Please answer ALL relevant questions fully, not doing so could result in delays in processing this claim.

SECTION A – Background Details

Policy Number	<input type="text" value="MP7000"/>	Policy Owner	<input type="text" value="CCSL Limited"/>	ROSS Employer No	<input type="text" value="MP7"/>
Plan Name	<input type="text"/>				
Employer Name	<input type="text"/>				
Business Address	<input type="text"/>				<small>Postcode</small>
Full Name of Employee	<input type="text"/>	Date of Birth	<input type="text" value="/"/>	<input type="text" value="/"/>	<input type="text" value="/"/>
Employee Address	<input type="text"/>				<small>Postcode</small>
Date joined Employer	<input type="text" value="/"/>	Date joined Plan	<input type="text" value="/"/>	Employee's last physical day at work	<input type="text" value="/"/>

If the benefit is linked to salary please provide the annual income details below:

What was the employee's gross annual income, as defined, at the last renewal date?	<input type="text" value="\$"/>	What was the employee's gross annual income immediately prior to disability?	<input type="text" value="\$"/>
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- Date of Death?
- Was the employee at work and performing the usual duties of their occupation on the date they joined the plan? Yes No
 - If 'No', please provide details why they were not at work/not able to perform usual duties.
 - If on modified duties, what was the nature of duties performed?
 - How did these differ from their usual duties if they were at work on modified duties?
- Was the employee still employed by your company on the date of their death? Yes No
If 'No', please state the reason why (i.e. resignation, retirement, retrenchment, ill health, etc.).
- Please provide any additional information or comments you feel are relevant to this claim.

Declaration

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 understand and agree that the insurer, AIA Australia, may provide the Policy Owner/Trustee of the above plan with copies of this statement.

Name in Full <small>(please print)</small>	<input type="text"/>		
Job Title	<input type="text"/>	Telephone	<input type="text"/>
E-mail	<input type="text"/>	Facsimile	<input type="text"/>
Signature	<input type="text"/>	Date	<input type="text" value="/"/>



Corporate Electronic Funds Transfer (EFT) Details

ROSS Employer No.

Bank Name

BSB Number -

Account Number

Account Name