Loss of Income

TO BE COMPLETED BY THE CLAIMANT'S EMPLOYER (OR ACCOUNTANT IF SELF-EMPLOYED)

Claimant's Name

Employer/Company Name

Contact Person

Postal address

Suburb State Postcode

Phone: (Bus. Hours) Mobile:

Email

Employment Status ☐ Full Time ☐ Part Time ☐ Casual ☐ Self Employed

Employment Details

Employee's NET weekly salary $

Employee's GROSS week salary $

IF SELF-EMPLOYED OR CASUAL, PLEASE PROVIDE AVERAGE WEEKLY SALARY BASED ON 12 MONTH PERIOD DIRECTLY PRIOR TO INJURY.

Injury Details

Date employee ceased work (dd/mm/yyyy)

Date expected to resume duties (dd/mm/yyyy)

Return to Work

Has the Employee returned to work? If YES, what date did the Employee return? ☐ Yes ☐ No

Salary Received

During the period of incapacity, has the employee received a salary? If YES, what for? ☐ Yes ☐ No

Sick Leave ☐ Yes ☐ No

From (dd/mm/yyyy) To (dd/mm/yyyy)

Annual Leave ☐ Yes ☐ No

From (dd/mm/yyyy) To (dd/mm/yyyy)

Other ☐ Yes ☐ No

From (dd/mm/yyyy) To (dd/mm/yyyy)

Net of business expenses, personal deductions and income tax; excludes bonuses, commissions and all other allowances.Excludes income derived from playing sport.

Employer's Declaration

By signing the declaration below, you confirm and agree to the following:

(A) You are the Claimant's current employer (or accountant if the claimant is self-employed),

(B) After reasonable inquiry, you confirm the employment and salary details supplied herein are true and accurate,

(C) You will supply upon request any further information as required for the determination of this claim.

Employer's Signature: ** Accountant's signature (if claimant is self-employed)*

Date Date (dd/mm/yyyy)

Gallagher