Level 9 FNPF Place, 343 – 359 Victoria Parade, Suva Ph. (679) 330 2717 Fx. (679) 330 2119
Western branch: 117 Vitogo Parade, Lautoka. P.O. Box 7362, Lautoka. Ph. (679) 666 5717 Fx. (679) 666 9711

EMPLOYERS REPORT

(In Conjunction with a Total and Permanent Disablement Claim Under a Mortgage Protection Policy)

Members Name: Mr/Mrs/Ms……..…… ……..……

Address: ……...……...

Commencement Date of Employment with the Company: ……..…/……/……

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1. What was the member's occupation at the date of disability?

   ……...……..…

   ……

2. What duties were involved? (If the Member had a job description, please attach it to this report).

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   ……..……..…

   ……

3. Has the Member performed any other occupation/s while employed with your Company?

   YES **NO**

   If 'yes' Please provide details of the occupation(s), including a full description of the duties.

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4. If the Member was employed for less than 2 years with your Company, please state name and address of previous employer?

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   ……

5. On what day was the Member last actively at work? ……/……/……

6. On what date did his/her employment cease with the Company? ……/……/.....

7. What reason(s) were given by the Member for ceasing work? ……..

   ……

   ……

8. Was there a Worker's Compensation settlement?

   YES **NO**

   If Yes, please provide the name, address and the claim number of the Worker's Compensation Insurer.

   ……

   ……

9. Have any alternative duties or employment been offered to the Member? **YES** **NO**

If 'No' please state the reasons. …… … ….

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If 'yes' please provide details of:

(a) the alternative duties of employment offered ……..…

……

……..……

(b) how long the Member worked at those duties ……..……

……..……

(c) the reason for ceasing. ……

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ADDITIONAL REMARKS

Are there any comments you would like to make that would assist FijiCare Insurance Limited with its assessment of the Member's claim?

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Signature: ……. Position in Company: ……

Company Name: ……

Name in full: ……..… Date: ……/……/……

(please print)

Telephone: ……