ZURICH

Recurrence of Disability

TO BE COMPLETED WHERE A WORKER HAS LOST FURTHER TIME FOLLOWING A RETURN TO WORK OR WHERE THERE HAS BEEN A RENEWAL OF TREATMENT OF THE ORIGINAL DISABILITY.

ATTACH MEDICAL CERTIFICATE AND REPORTS IF AVAILABLE.

CLAIM NO. (Office use only) | PPS Yes ◯ No ◯

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1 Worker

Surname | Other Names

Address | Postcode

Current Employer | Claim No. (if known)

Employer at time of original disability

Nature of disability

Date of original disability/injury / / | Date of further period of capacity / /

Date of return to work / /

2 Recurrence details

1. (a) Describe in detail where you were and what you were doing when the latest onset of symptoms or incapacity occurred

(b) If a further incident occurred, please provide details of this further incident

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2 Recurrence details (continued)

2. Were there any witness to the onset of further symptoms? Yes ◯ No ◯

If 'Yes', provide names and address, and attach statements

3. Was the onset of symptoms reported? Yes ◯ No ◯ If 'Yes', when? / /

and to whom?

4. (a) State what symptoms, if any, you have been experiencing leading up to the latest onset of symptoms

(b) What medical treatment have you been receiving prior to the latest onset of symptoms?

State the names of treating Doctors and dates of treatment

5. Give full details of your employment between the date of the original disability and current disability.

Supply names of all Employers, dates worked and Occupation

3 Declaration

I solemnly and sincerely declare that each and every answer above and the particulars contained herein or annexed hereto relating to myself and the occurrence are true both in substance and in fact to the best of my knowledge and belief.

I take notice that under the provisions of Section 59 (l) of the Workers' Compensation and Rehabilitation Act, 1981, I am required to notify my Employer within 7 days should I commence work with another Employer after making a claim or while receiving weekly payments of workers' compensation.

I hereby authorise any Doctor to divulge to my Employer, or their Insurer, information in relation to my claim for workers' compensation which he or she may have acquired with regards to myself.

Dated this day of 20

Signature of Worker Date

✗ / /

Signature of Witness Date

✗ / /