

Employment and Earnings Declaration

Claimant's Personal Details

1 Veterans' Affairs number (if known)

2 Title (tick) Mr Mrs Ms Dr Miss Other

3 Last name

4 First name/s

5 Date of birth / /

6 Date I started working / /

7 My tax code

8 My personal IRD number is

9 Are you still working? No Yes Go to question 12

10 Date I finished working / /

11 I received the following payments when I left my employment

	Before tax	After tax
<input type="checkbox"/> Sick Pay	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Holiday Pay	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Termination Pay	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Redundancy Pay	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Other payment	\$ <input type="text"/>	\$ <input type="text"/>
<input type="checkbox"/> Other source of earnings	\$ <input type="text"/>	\$ <input type="text"/>

12 What type of work do you do?

Full-time Part-time Casual

Seasonal Voluntary Self-employed or trustee, go to question 14

13 Employers details

Employers Name	
Employers Postal Address	
Country (if not New Zealand)	Post Code
Phone	Mobile Number
E-mail Address	

Breakdown of your income

14 What have you been paid?

	Week ending	Amount before tax	Amount after tax	Hours worked
1	/ /	\$	\$	
2	/ /	\$	\$	
3	/ /	\$	\$	
4	/ /	\$	\$	
5	/ /	\$	\$	
6	/ /	\$	\$	
7	/ /	\$	\$	
8	/ /	\$	\$	
9	/ /	\$	\$	
10	/ /	\$	\$	
11	/ /	\$	\$	
12	/ /	\$	\$	
13	/ /	\$	\$	
14	/ /	\$	\$	
15	/ /	\$	\$	
16	/ /	\$	\$	
17	/ /	\$	\$	
18	/ /	\$	\$	
19	/ /	\$	\$	
20	/ /	\$	\$	
21	/ /	\$	\$	
22	/ /	\$	\$	
23	/ /	\$	\$	
24	/ /	\$	\$	
25	/ /	\$	\$	
26	/ /	\$	\$	

	Week ending	Amount before tax	Amount after tax	Hours worked
27	/ /	\$	\$	
28	/ /	\$	\$	
29	/ /	\$	\$	
30	/ /	\$	\$	
31	/ /	\$	\$	
32	/ /	\$	\$	
33	/ /	\$	\$	
34	/ /	\$	\$	
35	/ /	\$	\$	
36	/ /	\$	\$	
37	/ /	\$	\$	
38	/ /	\$	\$	
39	/ /	\$	\$	
40	/ /	\$	\$	
41	/ /	\$	\$	
42	/ /	\$	\$	
43	/ /	\$	\$	
44	/ /	\$	\$	
45	/ /	\$	\$	
46	/ /	\$	\$	
47	/ /	\$	\$	
48	/ /	\$	\$	
49	/ /	\$	\$	
50	/ /	\$	\$	
51	/ /	\$	\$	
52	/ /	\$	\$	



If you prefer, please attach your payslips for the last 52 weeks, rather than completing the table.

15 What was the total amount received, including the extra payments at question 11?

Before tax	After tax
\$	\$

Business/income details

16 What is your trade/business?

17 What is the name of the business/trust?

18 What date did the business/company begin to operate? \ \

19 Business IRD number

20 What is the balance date of the business/company?

21 Do you operate your business/company

- In partnership (i.e. with other persons)? or **go to Q.22**
- as a limited liability "Ltd" company (in which you are a shareholder)? or **go to Q.23**
- as a sole trader (i.e. alone)? **go to Q.24**

22 If in a partnership, how many partners are there?

How are profits shared?

Please list the names of all the partners in the business:

23 If a limited liability company, how many shares do you hold?

Who are the directors of the company?

24 If you are involved in any other business or occupation other than what is listed

Please give details below:

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Before incapacity

25 When did you first start self-employment or work as a shareholder employee?

Please state the number of hours and days you normally work each week in your business or company.

	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Total	
								Hours	Days
Hours:									

24 Please state the hours worked in each of the four weeks immediately before this incapacity.

Week 1:	Week 2:	Week 3:	Week 4:
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Are these the typical hours normally worked in your business or company?

No Yes If no, state the hours normally worked

Please describe the range of duties you normally did before the injury?

After incapacity

25 What input do you currently have into the business or company? Include management and overseeing work

Give details of duties you are now unable to do:

26 How many hours did you work each week **following the start of your incapacity?**

Week 1:	Week 2:	Week 3:	Week 4:
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1. Is the business or company continuing to function? No Yes
2. If self-employed, is the business continuing to earn income? No Yes
3. If a shareholder employee, are you continuing to receive any income from the company?
 No Yes

If yes to any of the above, give details:

Has your tax return for the most recently completed financial year been lodged with Inland Revenue?

No Yes

If yes, when was it loaded? Date : \ \

Do you have a Tax Exemption Certificate (1R331) for the current financial year? No Yes

27 Accountant / Financial Advisor Details

Name:	Telephone:
Address:	

Privacy Statement

You can read our full privacy statement on our website

Your personal information is managed in accordance with the privacy statement on our website:

- www.va.mil.nz/privacy

If you would like a copy of this posted to you please contact us:

- 0800 483 8372 from New Zealand
- +64 4 495 2070 outside New Zealand

Signature

This form must be signed either by the claimant or a person with the authority to act on the behalf of the claimant if they are unable to do so.

If the claimant didn't sign the form, **include one** of the following forms of evidence:

- Power of Attorney or Enduring power of Attorney (in relation to Property)
- Certificate of Administration (from the Public Trustee)

I acknowledge that:

- the information I have given in this claim form is true and correct
- Veterans' Affairs may obtain further information to assess and decide on my claim
- I have read and understood the Privacy Statement for Forms on www.va.mil.nz/privacy
- I authorize the collection and disclosure of health, clinical, or other personal information by or to Veterans' Affairs, held by any doctor or health practitioner or named agencies, or service providers, or contractors for the purposes set out in the privacy statement; for the purposes of assessment of this claim; administration of any resulting entitlement; and the provision of any services, treatment or rehabilitation under the Veteran's Support Act 2014.

Signature | Please sign

Claimant or authorised person

Claimant or authorised person name

Claimant or authorised person signature

DD / MM / YYYY

Helper | Complete this section if you've helped the claimant to complete this form.

Helper name

Helper's relationship to claimant