EMPLOYER WAGE REIMBURSEMENT INVOICE

Return Email: workerscompclaims@iag.com.au
Return postal address:
CGU Workers Compensation Claims
Reply Paid 85245
WELSHPOOL DC WA 6986
Return Fax: 1300 038 395

Claim information

CLAIM NUMBER

CLAIMANT'S NAME:

DATE OF INJURY: D D / M M / Y Y

BUSINESS NAME:

ABN

EMPLOYER'S ADDRESS (POSTAL ADDRESS FOR PAYMENT):

EMPLOYER'S EMAIL ADDRESS:

Return to Work Information

NO ☐ PLEASE PROCEED TO 'REIMBURSEMENT CALCULATION' IN THE TABLE BELOW. NO 'GROSS/ACTUAL EARNINGS' WILL APPLY

YES ☐ D D / M M / Y Y PLEASE COMPLETE 'GROSS/ACTUAL EARNINGS' AND ENSURE THIS IS DEDUCTED FROM THE WORKER'S ENTITLEMENT AND AMOUNT TO BE CLAIMED.

IF THE WORKER HAS RETURNED TO THEIR FULL PRE-INJURY ROLE, PLEASE CONTACT YOUR CLAIMS CONSULTANT TO DISCUSS ENTITLEMENTS.

IF YOU ARE CLAIMING TIME LOST VISITING DOCTOR, PLEASE PROVIDE A COMMENT NOTING THE DATES AND HOURS LOST AT EACH VISIT

Reimbursement Calculation

TIME PERIOD		WEEKS	DAYS	HOURS	WEEKLY COMPENSATION RATE	GROSS/ACTUAL EARNINGS (IF APPLICABLE)	TOTAL AMOUNT CLAIMED
FROM	TO						

To assist with prompt processing of the payment

A workers compensation medical certificate must be provided confirming the incapacity period. If there are any restrictions this should be detailed in the return to work plan.

Employer Comments

Employer Declaration

I confirm, to the best of my knowledge that the information provided and attached is true and accurate.

NAME

SIGNATURE

DATE D D / M M / Y Y