

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 Policy number									
Business name				ABN					
Employer's Address (postal address for payment)									
Employer's email address									
Return to Work Information									
Has the worker returned to work?									
No Pl	No Please proceed to 'Reimbursement Calculation' in the table below. No 'Gross/Actual Earnings' will apply.								
Yes D D / M V / Please complete 'Gross/Actual Earnings' and ensure this is deducted from the worker's									
		entitlement and amo							
	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									
Period (inclusive dates) Please complete one week per line (excluding date of injury)		Normal Weekly Earnings (NWE)	Gross/Actual Earnings (for work performed - if applicable)	NWE less Earnings (Total Claimed)					
From	То								

After 26 Aggregate Weeks (Section 65)

Period (inclusive dates) Please complete one week per line		Normal Weekly Earnings (NWE / INWE)	Gross/Actual Earnings (if applicable)	NWE / INWE less Earnings	X 75% - 90% (Total Claimed)
From	То				
				Total	

Please note;

Section 65 reduction after 26 aggregate weeks.

X 75% - 90% (Entitlement). The maximum entitlement payable for a worker after 26 aggregate weeks is 150% of Average Weekly Earnings. The date of injury cannot be claimed. Please contact your Claims Consultant to obtain the AWE figure for the current year.

To assist with prompt processing of the payment

Please provide pay advice to support wage reimbursement.

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

