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

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 ☐ 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

First 26 Aggregate Weeks (Section 64)

Period (inclusive dates) please complete one week per line		Normal Weekly Earnings (NWE)	Gross/Actual Earnings (if applicable)	NWE less Earnings (Total Claimed)
From	To			

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	To				

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. Please contact your Claims Consultant to obtain the AWE figure for the current year.

To assist with prompt processing of the payment

Please provide payslip 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

D D / M M / Y Y

Insurance Australia Limited
ABN 11 000 016 722
trading as CGU Workers Compensation