Employers Mutual
Since 1910

Weekly Payment Reimbursement Request (WPRR)

This form is intended to assist employers seeking reimbursement for weekly income support payments made to a worker.

Use one form per worker. Please email **WPRR@eml.rtwsa.com** if you need assistance completing this form.

This form must be submitted within 3 months from the date you paid the worker the payment you are seeking to be reimbursed.

* If this is your first reimbursement request, the first date you can claim will be from the first date of incapacity (if you have been waived the first 2 weeks) to the end of your pay week.

**Notional Weekly Earnings. Worker's average weekly earnings or where adjusted, the adjusted average weekly earnings.

Mandatory Requirements for Reimbursement

1. Evidence of payroll records must be attached for all weeks being claimed.
2. All Annual/Personal Leave has been excluded from earnings and has not been paid in lieu of Income Support.
3. Only one week may be recorded per line.
4. Only include payments within the accepted claim period. Please refer to your claim acceptance/ discontinuance letter for dates.

NAME OF WORKER	CLAIM NUMBER	FIRST DATE OF INCAPACITY*	NOTIONAL WEEKLY EARNINGS**

NAME OF EMPLOYER (AS PER REGISTRATION)	RTWSA REGISTRATION NO.	LOCATION NO.	EMPLOYER ABN

Period Claimed		Incapacity			Earning From Work Performed	Hours worked	Date Worker Paid
From	To	Totally Unfit	Partial (Suitable Duties)				
			Working	Not Working			
		❑	❑	❑			
		❑	❑	❑			
		❑	❑	❑			
		❑	❑	❑			
		❑	❑	❑			
		❑	❑	❑			
		❑	❑	❑			
		❑	❑	❑			
		❑	❑	❑			
		❑	❑	❑			

Name of Person completing this form:

Contact Email Address:

Contact Phone Number:

I declare that weekly payments of income support have been paid to the worker in accordance with the Return to Work Act 2014.

Signed:

PRINT EMAIL SAVE

AGENT OFFICE USE ONLY

I (Claim Specialist), approve payment of these WPRRs and confirm that the details of this form match my knowledge of the worker's expected earnings from employment.

we help people get their lives back