

EMPLOYER WAGE REIMBURSEMENT INVOICE

Return Email: workerscompclaims@iag.com.au Return postal address: CGU Workers Compensation Claims Reply Paid 91571 MELBOURNE VIC 8060 Return Fax: 1300 038 395 **Claim information** Claim Number: Claimant's name: Date of Injury: Policy number: ABN: Business name: Employer's Address (postal address for payment): Employer's email address: **Return to Work Information** Has the worker returned to work? Please proceed to 'Reimbursement Calculation' in the table below. No 'Gross/Actual Earnings' will apply. No Yes 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. **Reimbursement Calculation** Weekly Compensation Rate Date effective from D D / M M / Y Change to weekly compensation rate

Period (inclusive dates)		Weekly Compensation Payable for this	Gross/Actual Earnings (if applicable)	Weekly comp payable less earnings	Less Step Down % (if applicable)	Total Claimed
From	То	period				

Please note step downs that apply;

- a. 100% of the weekly payment for the first 26 weeks of the period of incapacity;
- **b.** 90% of the weekly payment for the period of incapacity exceeding 26 weeks but not exceeding 78 weeks from date of initial incapacity;
- **c.** 80% of the weekly payment for the period of incapacity exceeding 78 weeks.

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	
Employer Declaration	
I confirm, to the best of my knowledge that the information provided and attached is true and accurate.	
Name	
Signature	Date

