

## **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 Fa	<b>x:</b> 1300 0	38 395						
Claim ir	ıformati	on						
Claim Num	ber:		Claimant's name:					
Date of Inju	-							
		'						
Business n	ame:				ABN:			
Employer's	Address	(postal address for payment):						
Employer's	email add	dress:						
Return	to Work	Information						
Has the wo	orker retur	ned to work?						
No	Please	proceed to 'Reimbursement Calculation' in the table below. No 'Gross/Actual Earnings' will apply.						
Yes Date D / M / / Please complete 'Gross/Actual Earnings' and ensure this is de worker's entitlement and amount to be claimed.						this is dedu	icted from	n the
				the worker has returned to their full pre-injury role, please contact your Claims Consultant to discuss entitlements.				
			If you are clair	ming Time Lost Visiting Doc	tor, please p	rovide a co	mment no	otina

## **Reimbursement Calculation**

Time Period		Weeks	Hours	Days	Weekly Compensation	Gross/Actual Earnings	Total Amount Claimed
From	То				Rate	(if applicable)	Glaimeu

the dates and hours lost at each visit

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

To assist with prompt processing of the payment

