MEDICAL AND/OR OTHER EXPENSES FORM

This form is to be completed when you are seeking reimbursement of medical and/or other expenses.

Please ensure you complete this form and attach a copy of your receipts for prompt reimbursement.
If the space provided below is insufficient, please attach a separate sheet.

Injured worker details

Claim Number

Surname

Given name(s)

Address

Postcode

Date of service	Service provider name	Service provided	Amount
D D / M M / Y Y			$
D D / M M / Y Y			$
D D / M M / Y Y			$
D D / M M / Y Y			$
D D / M M / Y Y			$
D D / M M / Y Y			$
D D / M M / Y Y			$
D D / M M / Y Y			$
D D / M M / Y Y			$
D D / M M / Y Y			$

*Receipts must be attached

Total $ 0.00

You can scan and attach your correspondence to an email and send to: **workerscompclaims@iag.com.au**
Please ensure our claim number is included in the subject line of your email.
Alternatively, you can use free postage within Australia (no stamp required) by addressing your envelope to:

NT and WA
CGU Workers Compensation Claims
Reply Paid 85245
Welshpool DC WA 6986

ACT and Tasmania
CGU Workers Compensation Claims
Reply Paid 91571
Melbourne VIC 8060

Signature

Date
D D / M M / Y Y

Insurer
Insurance Australia Limited
ABN 11 000 016 722 AFSL 227681
trading as CGU Workers Compensation