EMPLOYER INCOME COMPENSATION REIMBURSEMENT REQUEST

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:

Injured Worker's name:

Date of Injury

D D / M M / Y Y

Employer's 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.

Yes ☐ Date D D / M M / Y Y

If the worker's income compensation payments have been reduced pursuant to the Workers Compensation and Injury Management Act 2023, please complete the section 'Total wage paid to the Worker' in the table below and ensure the amount is deducted from the total amount to claimed.

If the worker has returned to their full pre-injury role, please contact your Claims Consultant to discuss entitlements.

Weekly income compensation rate: $

Reimbursement Calculation

Time Period		Weeks	Days	Hours	Total Income Compensation paid to the Worker	Total wage paid to the Worker (if applicable)	Total Amount Claimed
From	To						
							$
							$
							$
							$
							$
							$
							$
							$
						Total	$ 0.00

To assist with prompt processing of the payment

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

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

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