EMPLOYER INCOME COMPENSATION REIMBURSEMENT REQUEST

wfi Insurance

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

NO ☐ PLEASE PROCEED TO 'REIMBURSEMENT CALCULATION' IN THE TABLE BELOW.

YES ☐ 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

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