Workers Compensation Reimbursement Invoice

CGU Workers Compensation

Claim no. : : : : : : : : :

Policy no. : : : : : : : : :

Please print in block letters and answer all Questions ☑ where applicable (provide full and complete answers). If a particular question does not apply, please write "Nil" in the space provided. If the space provided below is insufficient to advise all the details, please attach a separate sheet.

Employer's details

Employer's name

Employer's reference no.

Address

Postcode

Worker's name

General questions

What are the worker's normal work days and regular hours?

Has the worker resumed duties?

No ☐ Yes ☐ Please indicate whether the worker has resumed:

Normal duties ☐ When? / / Hours/week

Lighter duties ☐

Period (inclusive dates)		Weeks	Days	Hours	Weekly rate	Amount
From	To					
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$
					Total	$

Is Direct Credit preferred?

No ☐ Yes ☐ Direct Credit form will be sent for completion.

IMPORTANT

1. **If compensation relates to time lost visiting doctor and is less than one day, show "TLVD" against period and indicate hours lost each visit.**
2. **Ensure that medical certificates supporting periods of absence are submitted.**
3. **Specify actual dates the worker lost time and do not use "week ending".**

Employer's signature

Name

Signature

Date / /