



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 clearly marked receipts on A4 paper 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
DD / MM / YY			\$
DD / MM / YY			\$
DD / MM / YY			\$
DD / MM / YY			\$
DD / MM / YY			\$
DD / MM / YY			\$
DD / MM / YY			\$
DD / MM / YY			\$
DD / MM / YY			\$
DD / MM / YY			\$
Total			\$

*Receipts must be attached

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:

WA and NT

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



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