Compensation reimbursement request

* Your request for reimbursement, together with the Medical Certificate, must be sent to your WorkSafe Agent within three months of the date you paid the worker.
* Reimbursements will not be made if you fail to request reimbursement within three months, in accordance with the legislation unless WorkSafe is satisfied that your delay in making the application is reasonable.
* WorkSafe reserves the right to verify your payroll records to support that you have paid the worker for the period claimed.

**Claim number:**

**Worker’s name:**

**Employer’s name:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Time period\*****Saturday – Friday** | **Days paid** | **Compensation rate** | **Total number of hours worked** | **Gross current weekly earnings (if any)** | **Amount of reimbursement claimed** |
| - |  |  |  |  |  |
| - |  |  |  |  |  |
| - |  |  |  |  |  |
| - |  |  |  |  |  |

\*Employer’s payment cycle

**Note:** please attach certificates for the entire period indicated above

|  |  |
| --- | --- |
| Has payment been made to the worker or do you intend to pay as per company pay schedule? | Yes  No (all requests for reimbursement) |
| Have you provided documented reasons for the delay in seeking reimbursements outside 3 months? | Yes  No  |
| Has the worker returned to work? If 'Yes': Suitable employment:Full pre-injury duties:If the worker has returned to work, ensure that worker’s gross current weekly earnings are indicated in the 5th column of the table above. | Yes  No  Date: / /  Date: / /  |
| Employer’s Signature: |  |
| Position: | Date: |  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **For agent's use only:**Reimbursement request form received on (date): \_ \_ \_ \_ /\_ \_ \_ \_ /\_ \_ \_ \_ \_ \_ Medical Certificate attached?: Yes  No Does the Medical Certificate cover the whole period claimed: Yes  No If 'No', what period is missing: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ |