Coal Mines Insurance Pty Ltd
REQUEST FOR PAYMENT

EMPLOYER:

This form is to be completed in accordance with instructions distributed by Coal Mines Insurance Pty Ltd.

Claim	Claimant's name	* EA / Award Weekly Rate	From/on date	To date	Wks	Days	Hours	Payment Code	Gross	Salary Sacrifice Deduction	Tax Rebate	Pay Via	Resumed work on
		* Rostered Days and Hours per week											
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* Please attach a copy of the Enterprise Agreement or Award for the Initial Payment of Workers Compensation

The information on this form is, to the best of my knowledge and belief, correct and relates to an injury which is compensable under the Worker's Compensation Act, 1987, as amended.

(Signed) .... Date ..../.........../...........

Manager or authorised officer