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CLAIM NUMBER _ _ _ _ _ _ _ _ _ _

Employer's Confirmation of Loss of Salary

FORM G

To be completed by the Claimant's Employer

(Please print neatly in BLOCK LETTERS and use a BLACK or DARK BLUE pen)

MAIB will only use personal information where it is lawful, reasonable and necessary and is managed in accordance with the *Personal Information Protection Act 2004 (PIP Act)*.

Personal information is collected and will be used by MAIB and its Agents to determine entitlement under The Act and accompanying regulations to common law damages and/or no fault benefits. Information collected may be used for other purposes permitted by the *Personal Information Protection Act 2004 (PIP Act)*.

Employee

Full Name

Date of Birth / /

Date of Accident / /

Employer

Business Name

Business Address

Postal Address (if different)

Phone Number

Fax Number

Email Address

Contact Person

Employment

Employment Commencement Date / /

Employment Status

☐ Full Time ☐ Part Time ☐ Casual
☐ Permanent ☐ Casual ☐ Temporary

Position Description

Brief description of duties ordinarily completed by employee

Earnings

Gross Earnings for the 12 month period ending on date of the accident $

If employed for a period fo less than 12 months – state gross earnings for the period employed until the accident date $

Details of Salary Sacrifice (if applicable)

Earnings Since Accident

Has any amount been paid to the employee during their absence? ☐ Yes ☐ No

If Yes:

From Date: / /

To Date: / /

Gross Amount: $

What were these payments for: ☐ Sick Leave ☐ Holiday Pay ☐ Workers Compensation ☐ Other (please specify)

Have these payments ceased? ☐ Yes ☐ No

Has the employee lodged a workers compensation claim in regard to this accident? ☐ Yes ☐ No

Return to Work

Has the employee returned to work? ☐ Yes ☐ No

If Yes:

Date of return / /

In what capacity has the employee returned?

As the employer, are you prepared to negotiate a *Return to Work* Program for the injured worker? ☐ Yes ☐ No

If Yes: Are you prepared to receive contact from a rehabilitation provider to assist in return to work? ☐ Yes ☐ No

If Yes: Details of person in which contact should be made with

Name:

Contact Phone Number:

Email Address:

Declaration

I declare that the information provided in this form, to the best of my knowledge and belief, is true and correct.

Full Name

Position Held

Contact Number

Email Address

Signature

Date / /

Checklist

Form G - Employer's Confirmation of Loss of Salary fully completed ☐

Attached the employee's latest payment summary and payslips showing year to date earnings for employment greater than 12 months ☐

or; payslips showing year to date earnings for employees less than 12 months