1st Floor,
33 George Street, Launceston
PO Box 590, Launceston 7250
DX 70112, Launceston
Telephone: (03) 6336 4800

TOLL FREE 1800 006 224

Facsimile: (03) 6336 4848
Email: info@maib.tas.gov.au
Website: www.maib.tas.gov.au

CLAIM NUMBER — — — — — — — — — —

Employer's Confirmation of Loss of Salary

FORM G

To be completed by the Claimant's Employer

The MAIB will ensure that any information provided for the purpose of calculating loss of salary entitlements for a person injured as a result of a motor accident, will remain confidential.

Employee's Personal Details

Question 1

Employee's Surname

Given Names

Date of Birth / /

Date of Accident / /

Name of Employer

Business Address

State Postcode

Postal Address *(if same as above, write "as above")*

State Postcode

Contact Numbers

Telephone: ( )

Fax: ( )

Your relationship to the injured person

Date employee commenced employment / /

Is employee full time or part time?

Is employee's position permanent, casual or temporary

Date employee was first absent as a result of the motor vehicle accident injuries / /

Has the employee returned to work? NO YES

If YES, date of return / /

Details of Salary Sacrifice (if applicable)

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

If employed for a period of less than 12 months, state gross earnings for the period of employment ending on the date of the accident. $

Note: ***When returning this document to MAIB please provide evidence to support the earnings paid above, i.e. Payment summary for the financial year ending prior to the date of accident or payroll summary report.***

Details of weekly wages prior to accident	Gross	Net
– First week preceding accident	$	$
– Second week preceding accident	$	$

Has any amount been paid to the employee during the employee's absence? ☐ NO ☐ YES

If YES

From (date)	To (date)	Gross Amount	Net Amount
		$	$
		$	$

Were these payments for:

☐ Sick Pay ☐ Workers' Compensation ☐ Holiday Pay ☐ Other

If other, please specify

Have these payments ceased? ☐ NO ☐ YES

If YES, the date these payments ceased / /

If NO, the date these payments will cease / /

Has the employee lodged a workers' compensation claim in regard to this accident? ☐ NO ☐ YES

As the employer, are you prepared to negotiate a *Return to Work* program for the injured worker? ☐ NO ☐ YES

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 in the company

Signature

Dated / /