Coal Mines Insurance

Request for Payment

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

Employer: _____ CMI to make payment to: Worker ◯ Employer ◯

Claim number	Worker's name	From date	To date	Days	Hours	Roster	Award Rate	Bonus	Type of compensation	Total

* Please attach a copy of the applicable Enterprise Agreement or Award for the initial payment of workers compensation.

* Claim for loss of earnings must be accompanied by the earnings and attendance records for the periods claimed.

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 Workers Compensation Act 1987 as amended.

Signed _____ Date _____

Manager or authorised officer