INSURANCE PROPOSAL

This form is to be used to provide essential information for the commencement of a workers compensation insurance policy.				
Policy Number:		CCI Client Number:		
Period of Insurance:	from		to	

1. Employer's Details

Registered Business Name: *(legal entity)*						
Trading Name:						
ABN:			ACN / ARBN:			
Trust Name:						
Trust ABN:						
Contact Person:						
Postal Address:						
	Suburb:		State:		Postcode:	
Work Phone			Mobile:			
Contact Email:			Contact Fax:			
Are you exempt from GST?	☐ Yes	☐ No	If no, are you registered for GST?		☐ Yes	☐ No
Do you have an input tax credit entitlement (ITC) of 100%	☐ Yes	☐ No	If No, entitlement?		%	

2. Business Activity

Please state your primary activity that applies to your business (for example church operation):

GPO Box 4143, Sydney NSW 2001
trinityinsurance.au
T: 02 8251 9199
T: 1800 469 931
F: 02 8251 9495
E: policy@trinityinsurance.au

3. Previous Insurance History

Insurance for last year			
Insurer's / icare Agent's Name:			
Policy Number:			
from:		to:	
Insurance for year before last			
Insurer's / icare Agent's Name:			
Policy Number:			
from:		to:	

4. Estimated Wages per Location

If you have more than one address, we are able to reflect any Cost Centre codes or names that you may use internally to refer to each site. Please note how you would like it to be referred to in the Cost Centre Name / Code space below.

Trading Name:					
Main Location Address:					
	Suburb:		State:		Postcode:
Cost Centre Name / Code:					

a. Direct Workers (including working directors)

Description of work performed	**Total Number of Workers**	**Total Wages** (gross wages + super + apprentices)	**Total Apprentice Wages** (apprentice wages + super)

b. Contractors

Number of Contractors	**Labour only ($)**	**Labour and Tools ($)**	**Labour and Plant ($)**	**Labour, Plant and Materials ($)**

Note: If you have more than two (2) addresses, please attach an additional sheet declaring the same information as above

5. Declaration

I

- declare that the information provided in this proposal and any attachments are true, correct and complete
- declare that no information has been suppressed or omitted from this proposal
- agree to supply a correct declaration of wages paid at the expiry period of insurance to allow an accurate calculation of premium. I understand that this declaration may result in further premium payable or a refund of premium paid, subject to the minimum premium, wages actually paid and actual claims costs for the period
- acknowledge and accept the terms and conditions detailed in the policy wording
- understand that if any information in this proposal is false or misleading, or there is willful failure to observe the terms of the policy of insurance, prosecution action may be taken
- acknowledge and accept that a requirement for being a member of Trinity Insurance is to meet the requirement to have a Work Health & Safety (WHS) system in place that is as a minimum of the same standard as the tool that is available to you from Trinity Insurance and that you will provide us information about your WHS practices prior to renewal of your policy each year

Signature:	Date:
Name in full:	Position / Title:

Please complete and return this form to Trinity Insurance:

GPO Box 4143, SYDNEY NSW 2001

policy@trinityinsurance.au

02 8251 9495

For information on our Privacy, Terms, and Whistleblower policies please refer to our website