| **Activity** | **Service Expectations** |
| --- | --- |
| **Employer** | **Trinity Insurance** |
| **Wages Payments** | * Provide Trinity Insurance with a copy of Employment Agreement, Contract of Employment or relevant award for the injured worker at notification or within 5 calendar days of notifying Trinity Insurance of the claim.
* Provide Trinity Insurance with 52 weeks of payslips prior to date of injury (or if period is less than 52 weeks then from date of employment) at notification of injury or within 5 calendar days of notifying Trinity Insurance of the claim.
* Wages paid by the employer to injured workers on a regular and ongoing basis should be in calculated in accordance with:
	+ Normal Payroll procedures
	+ For periods covered by appropriate Certificates of Capacity. (a current Certificate of Capacity is required for all payments of weekly compensation)
	+ At pay rates confirmed by Trinity Insurance
* Employer must pay the amount received from Trinity Insurance in full to injured worker less any income tax that is payable.
 | * Inform the employer and injured worker of the initial weekly wage rate in writing within 7 calendar days of receipt of notification of injury or 5 calendar days from when wage information has been provided by employer i.e. through the provisional liability or liability acceptance letter.
* Trinity Insurance will notify the employer within 5 business days of a change in the workers entitlement to weekly payments of compensation (e.g. from Section 36 payments to Section 37 payments) or when the following occurs: a Work Capacity Decision is made by Trinity Insurance, at the Second Entitlement Period and After the Second entitlement period.
* Wage payments reimbursed to the employer by Trinity Insurance are gross payments.
 |
| **Reimbursement** | * Wages are to be claimed from Trinity Insurance using approved reimbursement schedules.
* Reimbursement schedules are to be forwarded to Trinity Insurance within 5 business days of either:

Please choose:

|  |  |
| --- | --- |
| Fortnightly OR | [ ]  |
| Weekly | [ ]  |

  | * Trinity Insurance will reimburse wages submitted through a Trinity Insurance Wage Reimbursement Schedule within 10 business days of receipt.
* Payments can only be reimbursed in accordance with the correct benefit entitlement and for periods covered by a Certificate of Capacity.
 |
| Claims Administration  | * The employer agrees it has the financial and administrative resources to guarantee that payments of weekly compensation benefits will be made in a timely manner, consistent with the legislative requirements and can provide evidence of this if requested.
* All claim documentation; medical reports, medical certificates or evidence of a return to work regarding an injured worker will be forwarded to Trinity Insurance immediately on receipt thereof and not held until reimbursement schedules are forwarded.
 | * Trinity Insurance is to advise if a Certificate of Capacity is required to process payment.
 |
| **Excess**  | * Claims are to be notified to Trinity Insurance within 5 calendar days of the employer becoming aware of an injury.
 | * An excess applies to claims notified outside the 5 calendar day timeframe. This excess will be deducted by Trinity Insurance from the initial wage reimbursement on each claim. Excess is calculated as one weeks’ worth of workers compensation wage entitlements. Excess does not apply to recess or journey claims.
 |
|  **Compliance** | * Employer is to provide a reimbursement schedule for each claim with time lost and weekly benefits payable:

Please choose:

|  |  |
| --- | --- |
| Fortnightly OR | [ ]  |
| Weekly | [ ]  |

 | * Non submission of reimbursement schedules for a 3 month period or non-compliance with Section 69 of the *Workplace Injury Management and Workers Compensation Act 1998* may lead to the termination of this agreement.
 |

The Employer acknowledges that these arrangements apply to wage reimbursements claimed from Trinity Insurance and agrees that any failure on the Employer’s part to abide by these will lead to the termination of this agreement.

|  |
| --- |
| **Employer** |
| Employer Name: |       |  |  |
| Representative Name: |       | Representative Position: |       |
| Signature: |  | Date: |       /       /       |
|  |  |  |  |
| **Trinity Insurance** |
| Representative Name: |       | Representative Position: |       |
| Signature: |       | Date: |       /       /       |
|  |  |  |  |

**The terms of this agreement must not be released to a third party without prior written approval from Trinity Insurance.**