QBE Insurance (Australia) Limited
ABN 78 003 191 035

Workers Compensation Insurance Proposal

For the States of Western Australia, ACT, Northern Territory and Tasmania. Pursuant to the Workers Compensation legislation in force in the State or Territory for which this cover is proposed. Return completed form to: **Western Australia**, GPO Box N1116, Perth WA 6843; **ACT**, PO Box 1008, Civic Square 2608; **Northern Territory**, GPO Box 1659, Darwin NT 0800; **Tasmania**, GPO Box 1352, Hobart 7001

Office Use Only

Policy No.	Account	
ANZSIC	Client No.	Intermediary Name and ID

The Proposer/s

Full Name of Employer *(including any trade name or subsidiary companies, if any)*							
				Work Cover No. (WCN) *(WA only)*			
Telephone	( )	Fax	( )		E-mail		
Tax Status	Registered Business Yes ☐ No ☐			ABN		Taxable	%
Postal Address							
					State	Postcode	
Period of the Proposed Insurance		From	/ /		To 4pm on	/ /	
Full description of Business or Trade *(attach applicable brochures)*							
Location of Business Premises *(if more than one location, please specify)*							
					State	Postcode	
					State	Postcode	

General Information

Please answer 'Yes' or 'No' to the following questions in relation to your business:

Pre-employment medicals?	Yes ☐ No ☐
Induction program?	Yes ☐ No ☐
Employee Training program?	Yes ☐ No ☐
Schedule for plant/machinery maintenance?	Yes ☐ No ☐
Documented safe work procedures?	Yes ☐ No ☐
Alternative duties documented?	Yes ☐ No ☐
Have any charges been laid for breaches of OH&S legislation in the past 5 years?	Yes ☐ No ☐
Do you employ any Section 457 Visas and/or overseas seasonal workers?	Yes ☐ No ☐
Have you any employees likely to work overseas?	Yes ☐ No ☐
If 'Yes', which country?	

Contractors/Subcontractors

(a) Do you expect to contract out any of the work in connection with the business? Yes ☐ No ☐

(b) If the answer to (a) is 'Yes', will you satisfy yourself that contractors/subcontractors are insured for workers compensation by obtaining letters of indemnity from them and their insurer? Yes ☐ No ☐

(c) Alternatively, do you wish to include such indemnity in the insurance now proposed? Yes ☐ No ☐
If 'Yes', please complete the following in respect of the proposed period of insurance.

	Estimated amount for the proposed period of insurance			
Name of contractor/subcontractor and nature of work	Labour only $	Labour and plant $	Labour and materials $	Labour, plant and materials $

Note: States legislation may make you jointly and severally liable for a disability to Workers of Contractors and Subcontractors.

Details of Wages/Claims

Estimate of wages *(as per State definition)*

All		$
Other *(specify)*		$
Contractors/Subcontractors		$
Directors and Relatives		$
Employee numbers		

Note: 'Wages' means ALL amounts paid including overtime, bonuses, commission and allowances. Please refer to the legislation in your jurisdiction for a complete definition.

Details of wages/claims over last 5 years.

Policy Year	Employee Numbers	Actual Wages Paid	Number of Claims	Total Claim Amounts Paid	Total Claim Amounts Outstanding

Note: If there is insufficient space for any of the answers, continue on a separate piece of paper, sign and attach to this proposal form.

Directors and Relatives

Please list all employed members of an Employer's family residing in the Employer's dwelling. List all Directors of the Employer and remuneration.

Note: Any such persons NOT included in this Schedule are NOT insured.*

Name in Full	Age	Relationship	Occupation	Estimated Wages $	Value of keep and other allowances $

* For Tasmania, a person may be included under this Policy if they are not listed on this Schedule providing they meet the definition of a 'worker' under the legislation.

Details of Previous Insurer

Have all outstanding premium payments been finalised with your previous insurer?	Yes ☐ No ☐
Has any insurer permitted withdrawal of or declined any insurance?	Yes ☐ No ☐
Has any insurer cancelled or refused to renew a Policy?	Yes ☐ No ☐

If 'Yes', which insurer, what reasons were given?

	Name of Previous Insurer	Policy Number	Due Date
Last Year			/ /
One Year Ago			/ /
Two Years Ago			/ /

Declaration and Signature

I/We acknowledge that the information given is accurate and complete and that I/we have complied with the obligation imposed by law concerning disclosure of information.

I/We agree that this proposal shall, subject to the Terms and Conditions of the Policy, be the basis of the contract.

Signed _____ Date / /

Name *(please print)* _____ Position _____