## Insurance Proposal – Take Away Food Retailing

This form is to be used to provide essential information for the commencement of a workers compensation insurance policy.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Policy Number: |  | | | |
| Period of Insurance: | from | / / | to | / / |

# Employer’s Details

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

1. **Business Activity**



* 1. Please tick the activities that may also apply to your business:

|  |  |  |  |
| --- | --- | --- | --- |
| Food Trucks | Festivals | Dine in Facilities *(If yes, please advise % of dine in to take away)* |  |
| Other (please specify) |  | | |

* 1. Please tick the type of staff that your business employs:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Kitchen Staff | Cashiers | | Security |  |
| Delivery Drivers *(specify type of transport)* |  | | Other (please specify) |  |
| c. What are your operating hours?  *(For example, M-F 6am-6pm, Sat 9am-9pm)* | |  | | |
| d. How frequently is cash removed from the premises? | |  | | |

# 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: | / / |

# 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: |  | | | | | |

* 1. **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

# Related Corporations

|  |  |  |  |
| --- | --- | --- | --- |
| Is your organisation related to another company/subsidiary? | | Yes  If yes, please list details below | No |
| Related Corporation Name: |  | | |
| ABN: |  | | |
| Insurance Company of Related Corporation: |  | | |
| Policy Number of Related Corporation |  | | |

1. **Grouping of Related Employers**



If you are part of another organisation you are also part of a group. The HII specialised insurer license is excluded from SIRA grouping provisions, but for the sake of transparency, your policy will record details of existing group arrangements.

|  |  |  |
| --- | --- | --- |
| Are you a member of a group that pays combined wages in excess of $750,000? | Yes | No |
| If yes, what is your Group Number? |  | |

Note: Please refer to our privacy statement for information about our use of your information by visiting www.policy@hii.au

*Please see Declaration on next page*

# Declaration

I {print name}

* 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 Hospitality Industry 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 Hospitality Industry 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 Hospitality Industry Insurance:

**:** GPO Box 4143, SYDNEY NSW 2001

**:** [policy@hii.au](mailto:policy@hii.au)

**:** 02 8251 9495

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