



## EMPLOYER APPLICATION FOR MEMBERSHIP

Construction Income Protection Ltd. ACN 110 841 962

### EMPLOYER DETAILS

FULL EMPLOYER NAME (COMPANY NAME, SOLE PROPRIETOR OR PARTNERSHIP)

ABN

ADDRESS (STREET)

(SUBURB/TOWN)

(STATE)

(POSTCODE)

### CONTACT DETAILS

(E.G. PAY OFFICE)

TITLE

FIRST NAME

SURNAME

BUSINESS ADDRESS

TELEPHONE

MOBILE

FACSIMILE

E-MAIL ADDRESS

WHEN DOES YOUR NEXT PAY PERIOD END?

DAY  MONTH  YEAR

PAY PERIOD (PLEASE TICK)

WEEKLY  FORTNIGHTLY  MONTHLY

WHO WILL BE PARTICIPATING IN CIPQ?

ON-SITE WORKERS  ADMINISTRATION SUPERVISORY MANAGEMENT STAFF

**PLEASE COMPLETE REVERSE SIDE OF FORM**  
**CONSTRUCTION INCOME PROTECTION LTD - ACN 110 841 962**

PLEASE RETURN TO: CIPQ ADMINISTRATION, LEVEL 11/120 EDWARD ST, BRISBANE 4000. PO BOX 329 SPRING HILL 4004  
TOLL FREE: 1300 366 408 FAX: 07 3210 0088 WEB: [www.cipq.com.au](http://www.cipq.com.au)



**TO CONSTRUCTION INCOME PROTECTION LTD.**

Application is hereby made to become a B Class Member of Construction Income Protection Limited (the Company). I/We hereby agree to be bound by the Constitution and By Laws of the Company and to make Insurance Contributions to the Insurer in respect of each Insured Worker, at a rate to be determined by the Directors of the Company in accordance with the terms of the Constitution from time to time.

In accordance with clause 3.1 of the Constitution, I/We appoint (severally) the Company to be my agent:

- (i) to give notices required by Laws 2 and 3 to the Administrator;
- (ii) to receive from me and pay or deliver to the Insurer my Insurance Contribution;
- (iii) to select a reputable insurance company carrying on business in Australia as the Insurer; and
- (iv) to agree adjustment to Benefits in accordance with By Law 4.

I/We must pay:

- (i) my Insurance Contributions as and when required by the Insurer; and
- (ii) to the Company, on account of costs incurred in administering or supervising the recovery of any late payment of Insurance Contributions, an amount equal to the sum of any outstanding Insurance Contribution multiplied by the interest rate per annum from time to time prescribed by the Board for the period from the due date for payment of the Insurance Contribution until the Insurance Contribution is received by the Insurer.

This deed is take effect from: \_\_\_\_/\_\_\_\_/\_\_\_\_.

Signed by the employer on: \_\_\_\_/\_\_\_\_/\_\_\_\_ at \_\_\_\_\_ in the State of \_\_\_\_\_.

**COMPLETE ONLY THE SECTION BELOW APPROPRIATE TO YOUR BUSINESS STRUCTURE**

<b>COMPANY</b>	<i>TO EXECUTE HERE</i>
NAME ( <i>DIRECTOR</i> )	NAME ( <i>DIRECTOR/COMPANY/SECRETARY</i> )
SIGNATURE	SIGNATURE
AFFIX COMPANY SEAL ( <i>IF APPLICABLE</i> )	

<b>SOLE PROPRIETOR</b>	<i>TO SIGN HERE</i>
NAME	<i>IN THE PRESENCE OF (WITNESS NAME)</i>
SIGNATURE	SIGNATURE

<b>PARTNERSHIP</b>	<i>TO SIGN HERE</i>
PARTNER'S NAME	WITNESS NAME
SIGNATURE	SIGNATURE
PARTNER'S NAME	WITNESS NAME
SIGNATURE	SIGNATURE
PARTNER'S NAME	WITNESS NAME
SIGNATURE	SIGNATURE