

Practice Directive Number 1-2-3 (A)

Personal Optional Protection

Effective 01 January 2005

Section 2(2) of the *Workers Compensation Act* (the “*Act*”) grants the Workers’ Compensation Board (the “Board”) discretion to extend the application of Part 1 of the *Act* on terms directed by the Board to an employer or independent operator as though he or she was a worker.

The Board may direct such extension of Part 1 of the *Act* to a proprietor or a partner of a business by providing Personal Optional Protection. Personal Optional Protection is not available to a worker within the meaning of Part 1 of the *Act*.

As a consequence of the extension of Part 1 of the *Act*:

- a policyholder or a policyholder’s dependant is statute-barred from advancing or maintaining any cause of action or right of recovery against any employer within the scope of Part 1 of the *Act* or against any worker in respect of personal injury, disablement, or death arising out of and in the course of employment;
- a policyholder must:
 - comply with the provisions of the *Act*, regulations made thereunder, published policy of the Board, and any Practice Directive made thereunder, and
 - comply with all obligations of a worker applying for and receiving benefits under Part 1 of the *Act*,
- a policyholder is subject to occupational health and safety obligations under Part 3 of the *Act* and may be subject to administrative penalty per *Prevention Manual* item D24-2-1.

TERMS AND CONDITIONS

The relevant provisions of the *Act*, *Assessment Policy 1-2-3*, and this Practice Directive constitute the terms and conditions of the Personal Optional Protection contract.

These terms and conditions may be summarised on the Personal Optional Protection application form, a Board invoice, or other record or document of the Board. In the case of a conflict or ambiguity between any such summary and these terms and conditions, these terms and conditions shall prevail.

The Board may revise *Assessment Policy 1-2-3* and related practice directive from time to time without notice. Once published, any such revision is incorporated by reference into every continued Personal Optional Protection contract as at the due date of the next premium payable.

CONTRACT

Personal Optional Protection is a contract under which the Board provides services, compensation for pecuniary loss, or both, to a policyholder for

- (a) an injury arising out of and in the course of employment in accordance with section 5 of the *Act*, or
- (b) an occupational disease in accordance with section 6 of the *Act*,

in consideration of payment by the policyholder of a stipulated sum, called a premium.

APPLICATION FOR PERSONAL OPTIONAL PROTECTION

An applicant must complete and submit an application for Personal Optional Protection in the form provided by the Board. An altered, incomplete, or illegible application will not be accepted. Although the Board may request an applicant to complete or make legible an application, coverage will not be effected until the Board accepts the application.

An application may be submitted online or on the prescribed form by mail, fax, or in person.

DISCLOSURE OF MATERIAL FACTS

An applicant for Personal Optional Protection must advise the Board of every material fact (examples include: industrial undertakings, industrial processes and equipment used, contractual obligations) that may affect the risk of coverage; and, if an applicant is in any doubt as to whether a fact is material, the fact in question must be disclosed. The obligation to disclose every material fact is an ongoing obligation and continues throughout the term of coverage and at renewal of coverage.

ACCEPTANCE OF PERSONAL OPTIONAL PROTECTION

The Board may accept or refuse an applicant's application for Personal Optional Protection; but once the Board accepts an application for Personal Optional Protection, a legally binding contract is in effect between the Board and the policyholder.

The Board may confirm acceptance by internet, e-mail, or mail.

COMMENCEMENT OF PERSONAL OPTIONAL PROTECTION

Personal Optional Protection shall commence on the acceptance date, which shall be the latter of the date the Board accepts the application or the date requested in the application.

PERIOD OF COVERAGE

Unless Personal Optional Protection is granted to a date certain, coverage remains continuously in effect until:

- (a) the policyholder requests cancellation and receipt of such is acknowledged by the Board, or
- (b) cancellation is made by the Board.

AMOUNT OF PERSONAL OPTIONAL PROTECTION

An applicant may apply for coverage of not less than \$1,500 per month and not more than $\frac{1}{12}$ th of the annual maximum wage rate set forth in Appendix "A" of the *Assessment Manual*. If coverage for an amount of greater than \$2,500 per month is applied for, such amount will only be granted upon proof of earnings satisfactory to the Board; and, in default of such proof, coverage will be granted in the sum of \$2,500 per month.

A policyholder may apply in writing for an increase or decrease in the amount of coverage; and any such increase or decrease comes into effect once the Board accepts the policyholder's request for an increase or decrease in the amount of coverage.

PREMIUM PAYABLE

The monthly premium payable is the product of the monthly amount of coverage accepted by the Board multiplied by the applicant or policyholder's net rate (comprised of the experience rating adjustment, if any, and the base rate of the applicable classification unit).

A minimum premium equivalent to 30 days coverage will be charged on each Personal Optional Protection contract.

Premiums may be billed quarterly or annually.

CLASSIFICATION UNIT

The applicable classification unit is determined as follows:

- (a) if one classification unit represents more than 50% of the business' operations, in that classification unit,
- (b) if one or more classification units represent at least 25% of the business' operations, in the classification unit that has the highest base rate and represents at least 25% of the business' operations,
- (c) if no one classification unit represents at least 25% of the business' operations, in the classification unit coming closest to the 25% figure, and
- (d) in case of a tie, in the classification unit with the higher or highest base rate.

Upon discovering or determining that a policyholder is wrongly classified, the Board may retroactively change the classification and associated premium and shall notify the policyholder of the change and of any additional premium owing or refundable. A policyholder must pay any additional premium as invoiced and will be credited with any refund amount.

PREMIUM DUE DATE

Each premium is due and payable in full on or before the invoiced due date. However, the Board will allow a grace period of 25 days following the due date for full payment of the premium due. If full payment of the premium due is not made before or during the grace period, coverage shall lapse at the end of the grace period without further notice to the policyholder.

As *Assessment Policy 1-2-3* requires a policyholder to request either coverage up to a date-certain or cancellation of coverage, a renewing policyholder will be obligated to pay for the coverage provided during any prior grace period which terminated in a lapse of coverage.

The Board may, but shall not be under any obligation to, notify a policyholder that payment of a premium has not been received as required, but such notice does not obviate or diminish a policyholder's obligation to pay a premium in full before or during a grace period.

BENEFITS

See Schedule "A".

CANCELLATION OF PERSONAL OPTIONAL PROTECTION

A policyholder may request cancellation of Personal Optional Protection on line via the internet, by telephone, or by mailing, faxing, or delivering written request to the Board. Coverage will be cancelled when the Board acknowledges receipt of the notice of cancellation.

The Board may, at its sole discretion and without prior or concurrent notice to the policyholder, cancel coverage immediately upon the occurrence of any of the following:

- (a) determination that the policyholder did not or has not met the obligation (initial and ongoing) to advise the Board of every material fact that may affect the risk of coverage,
- (b) failure to pay the complete premium prior to the invoice due date or within the grace period of 25 days following its due date,
- (c) failure by the policyholder or the business of which the policyholder is a proprietor or partner to meet the requirements for mandatory coverage under the *Act*,
- (d) failure to provide information to the Board as requested from time to time by the Board or an officer of the Board,
- (e) failure to permit an officer of the Board to inspect a work site or premises or records,
- (f) failure to comply with an order or direction issued by the Board under Part 3 of the *Act*,
- (g) the policyholder's status for eligibility changes, in which case termination is effective the date of the change in status.

If the Board does cancel coverage as above, the Board must as soon as practicable notify the policyholder in writing of such cancellation; and for this purpose, the Board may mail a letter notifying of cancellation to the former policyholder's mailing address on record.

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT

Personal information on the application is collected under section 26 of the *Freedom of Information and Protection of Privacy Act* for the purpose of the administration of the *Workers Compensation Act*. For further information, please contact the Board's Freedom of Information Coordinator.

SCHEDULE “A”

BENEFITS

Where a policyholder suffers

- (a) an injury arising out of and in the course of employment in accordance with section 5 of the *Act*, or
- (b) an occupational disease in accordance with section 6 of the *Act*,

the policyholder may be entitled to:

- wage loss benefits for temporary partial or temporary total disability, in accordance with sections 29 or 30 of the *Act* and the Board’s relevant policies;
- health care benefits, in accordance with section 21 of the *Act* and the relevant Board’s policies;
- permanent total or permanent partial disability benefits, in accordance with sections 22, 23, and 23.1 of the *Act* and the Board’s relevant policies;
- retirement benefits, in accordance with section 23.3, 23.4, and 23.5 of the *Act* and the Board’s relevant policies; or
- vocational rehabilitation assistance, in accordance with section 16 of the *Act* and the Board’s relevant policies.

Wage loss, wage loss equivalency benefits, and permanent partial disability awards¹ are based on 90% of a policyholder’s average net earnings, which in accordance with sections 33.6, 33.8, and 33.9 of the *Act*, is the amount of Personal Optional Protection less the statutory defined “allowable deductions”. Generally, this means that:

- for the first ten (10) weeks of benefits, “net” is calculated based on 1.5 times the basic personal deduction for federal and provincial income tax. As well, a standard deduction is made for Employment Insurance premiums and Canada Pension Plan contributions, and
- after ten (10) weeks of benefits are paid, “net” is calculated on a more individualized approach. Unless exempt under section 33.9(c) of the *Act*, “net” is calculated based on the policyholder’s Employment Insurance premiums, Canada Pension Plan contributions, and probable income taxes as outlined in section 33.9(4).

All average earnings are subject to statutory maximum and minimum amounts in accordance with sections 25, 25.1, 26, 27, 29(2), 30(2), and 31 of the *Act*.

¹ Absent exceptional circumstances, permanent disability awards are calculated in accordance with section 23(1) of the *Act*; and the award is expressed as a functional percentage, based on the policyholder’s 90% average net earnings. However, in so exceptional cases, and in accordance with section 23(3) and the Board’s relevant policies, an award may be based on the difference between the average net earnings and the amount the policyholder is, or the Board estimates is capable of, earning.

Where a policyholder's death is work-related and meets the requirements of either section 5 or section 6 of the *Act*, benefits may be payable to surviving dependants in accordance with section 17 and the Board's relevant policies.

Full particulars of coverage may be found in Part 1 of the *Act*, the Board's *Rehabilitation Services and Claims Manual* and practice directives made thereunder, all of which are available at http://www.worksafebc.com/regulation_and_policy/.