PERSONAL ACCIDENT INSURANCE
PROPOSAL FORM (GROUPS)

INSURER: ----------

1. Full name of applicant principal/association Company

……..

1.2 Postal Address ……..……

1.3 Office Location ……..

Tel No…….. Fax No……

2. Description of activities/business or occupation

Please give number of employees/workers/members in the following categories

i) Administration (non-manual labour) ……..

ii) Supervisory roles ……..

iii) Supervisory & working roles ……..……

iv) Working roles (manual labour) ……..……..

v) Other (please give details). ……..

3. Please give names of employees/workers/members to be insured and the respective Capital Sums to be insured as per declaration list attached hereto.

Notes

1) The Company's standard cover provides the following benefits

a) Death Benefit: 100% of Capital Sums Insured

b) Permanent Total Disability Benefit: 100% of Capital Sums Insured

c) Temporary Total Disability Benefit: 1/52 of Annual Salary per week for 52 weeks

d) Medical Benefit up to 2% of Capital Sum

e) Business Limitations

f) Burns Disfigurement • Yes • No

2) The applicant/principal/association/company has the option to determine the limits of benefits preferable or adequate for (C) and (d) above.

4. Do employee/workers/members to be insured suffer from any Impairment of health? Yes No

If so, impairment must be indicated in the declaration list attached hereto.

5. Who is considered the beneficiary in the event of claim:

i) The applicant/principal/association/company Yes No
ii) The Insured or in the case of death the legal representative Yes No

6. Do you have any existing or previous Group Personal Accident Insurance?……

If yes, give details of:

i) the name of the Insurance Company ……
ii) the Capital Sum ……
iii) Date Issued……
iv) Expiry Date……

7. Has any insurance company declined your proposals for cover or refused renewal of your Policy?

……..

If yes, give details:

8 a) Have there been any accident/claims in your company/association in the last 3 years?

If yes, please give details

Year	No. of Accident/Claims	Amount of Claim	Claim Outstanding

9. Proposed Period of Insurance From:)
) Both days inclusive
To:)

DECLARATION

I declare and warrant that the above statements are complete and true in every respect and that no material information was been withheld or suppressed. I agree to give notice to the Company of any variation in my profession or occupation, health, or pursuits and that this declaration shall be held to be promissory and shall form the basis of the Contract between me and the …….. I further agree to accept a policy subject to the terms, provisions and conditions prescribed by the Company therein.

_____

SIGNATURE OF PROPOSER Date: _____

Note: The liability of the Company does not commence until the acceptance of the proposal has been intimated by the Company or official cover note issued.

GROUP PERSONAL ACCIDENT INSURANCE – DECLARATION LIST

Name of
Applicant/Principal/Association/Company……
……

Name of Employee/ Member to be Insured	Occupation/ Rank	Annual Salary	Benefits required
			Capital Sum/ Permanent Disability

Signature of Proposer …….
Date:……