**GROUP PERSONAL ACCIDENT PROPOSAL FORM**

**This insurance provides cover in the event that your employees suffer injury or death following an accident on a 24-hour basis. The benefits covered are:**

**Accidental Death:** Pays the specified fixed benefit or multiple of annual salary covered in the policy.

**Accidental Permanent Disability:** The extent of the benefits is determined by a qualified Medical Practitioner but subject to the policy limit.

**Accidental Temporary Disability:** Pays weekly benefits up to a maximum of 104 weeks for the period an employee is off duty as determined by a qualified Medical Practitioner.

**Accidental Medical expenses:** Reimburses actual medical expenses incurred but subject to the policy limit.

1. **PROPOSER DETAILS**

**FOR INDIVIDUAL APPLICATIONS**

1. Name: …………………………………………………………………………………………………...
2. Date of Birth: ……………………………………………………………………………………………
3. Passport/ ID Number: …………………………………………………………………………………

**(Please attach copy of ID/Passport)**

1. Nationality: ……………………………………………………………………………………………..
2. Physical Address: ………………………………………………………………………………….......
3. Telephone Number (s): .……………………………………………………………….....................
4. Email Address: …………………………………………….…………………………………..............
5. Trade / Occupation: ………………………………………………………………………………….
6. Physical address of Trade/ Occupation: …………………………………………………………
7. Source of income: …………………………………………………………………………………….

**FOR CORPORATE APPLICATIONS**

1. Registered name of the organization: …………………………………………………………….
2. Registration number of the organization: ………………………………………………………...

**(please attach copy of the registration certificate and TIN)**

1. Source of funds: ……………………………………………………………………………………….
2. Registered physical address of the organization:

…………………………………………………………………………………………………………….

1. Name of the CD/ MD/ ED / CEO /Authorized representative: ……………………………………………………...............................................................................
2. Date of Birth: ……………………………………………………………………………………………
3. Nationality: ……………………………………………………………………………………………..
4. Passport/ ID number (please attach copy): ……………………………………………………..
5. Telephone number(s)…………………………………………………………………………………
6. Email address(es): …………………………………………………………………………………………………………….
7. Names of shareholders

**(please attach their ID/ Passport copies)**

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1. Shareholding details

**(please attach copy of memorandum and articles of association)**

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1. **RISK DETAILS**
2. ***Is Cover required? – Please tick one***
3. On 24 Hour basis or Occupational basis (while at work)?
4. On Fixed benefits or Multiple of annual earnings?
5. ***If cover required is on fixed benefits, state the benefit per person under the following categories:***
	1. ***Death SSP………………….***
	2. ***PTD SSP……………………..***
	3. ***TTD SSP……………………..***
	4. ***Medical cover SSP………………..***
6. ***If cover required is on multiples of annual earnings, provide the following information per person covered:***
	1. ***Number of years’ salary/ earnings for Death and PTD……………. Years***
	2. ***Medical cover SSP………………***
7. ***Will any of the persons to be insured use machinery?***

If answered YES please give details of machinery used .…………………………………

1. ***Details of persons to be covered***

Please give details of persons to be covered *(alternatively provide a list in the same format)*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *CATEGORIES/**OCCUPATIONS OF PERSONS COVERED* | *ESTIMATED* *NO. OF PERSONS*  | *ESTIMATED ANNUAL EARNINGS* | *DEATH BENEFIT COVER*  | *PTD BENEFIT COVER*  | *TTD WEEKLY BENEFIT COVER*  | *MEDICAL EXPENSES* |
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1. ***Loss History***
2. Have any persons while engaged in the occupations stated been involved in the last three years in any accident resulting in death or disablement?(YES) (NO)

If yes give details……………………………………………………………………………………

1. Are you at presently insured? (YES) (NO)

or

1. Have you ever proposed for Group Personal Accident insurance in respect of your employees? (YES) (NO)
2. Has any insurance company ever:-
3. Declined your proposal? (YES) (NO)
4. Required an increased premium? (YES) (NO)
5. Imposed special terms or conditions? (YES) (NO)
6. Cancelled or refused to renew your policy? (YES) (NO)

If the answer to any of the above is yes please give details……………………………….

……………………………………………………………………………………………………..

1. ***Period of Insurance*:** From ………………………………To ………………………………………
2. **DECLARATION**

I warranty that the above statements made by me or on my behalf are true and complete to the best of my knowledge and belief and I agree that this proposal shall be the basis of the contract between me and the company. I also agreed to accept a policy in the company’s usual form for this class of insurance.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_