

Work Injury Benefit Insurance Form

(For membership to be considered this declaration must be completed in full and all questions answered)

Part A: Details Of The Proposer

1. Name Of Proposer _____
2. Postal Address _____ Postal Code _____ Town _____
3. Telephone No. (Office) _____ Mobile No _____
4. Email Address _____
5. Pin No. _____ Id No / Certificate Of Incorporation _____
(Attach Copy Of Each)
6. Business / Occupation being carried out in the building _____

Part B: Risk Details

7. Does any law or regulation governing the conduct or mainrenance apply to your premises? Yes No
If yes, name such laws or regulations _____
Have you carried out all obligations imposed on you by such laws and regulations? Yes No

- 8a) Do you have any circular saws or other machinery riven by steam, gas water or electricity? Yes No
b) Do you have any boilers Yes No
c) Are your works and or plant properly fenced and guarded and otherwise in good order / condition?
Yes No
d) Do you ude any acids, gases, chemicals or explosives? Yes No
If to any of the above, please give details _____

9. Are you at present insuredor have you ever been insured for Work Injury Benefits policy? Yes No
If yes, please give details _____

10. Has any insurance company or underwriter ever: Cancelled your policy? Yes No
Declined to insure you? Yes No Refused to renew your policy? Yes No
If you answer any of the above is yes, please give details _____

11. Have you in the last 3 years suffered a loss in connection with the type of insurance now proposed?
Yes No

If yes, please give details indicating the date of loss, nature of loss and cause of loss

12. Do you have any employee with a pre-existing medical condition? Yes No

12. Do you have any employee who are apprentices or trained in your organisation? Yes No

If yes, please state how many they are and estimated annual wages payable

LIST ALL EMPLOYEES BEING WORKERS AS DEFINED BY SECTION 5 OF THE WORK INJURY BENEFITS ACT 2007

For Official Use Only

Name / Number of Employee	Description of occupation	Estimated annual salaries / wages other earnings on which premium is based	Rate	Premium	Classification

Please use separate list with similar format if the space provided is not sufficient

Period of Insurance: From _____ to _____
Date /Month /Year Date /Month /Year

Agency/Broker _____ Mobile No _____

DECLARATION

I/We the undersigned desire to effect insurance for our employees within the meaning of Work, Injury benefits Act 2007. I/We agree to keep detailed records of all employees and to submit within 30 days after the end of each insurance period, a statement in the form required by the company of all wages, salaries or other earnings which shall be duly certified by our Auditors and to pay premium on any amounts in excess of the amounts above. I/We further declare and warrant that the statements given above are true and complete and that I/We have not suppressed, misrepresented or incorrectly stated any material facts and that I/We have fairly stated the total amounts of wages, salaries and other earnings. I/We agree that this proposal and declaration shall be the basis of the proposed contract between the company and myself/ourselves and accept a policy on the usual company terms and conditions for this class of insurance.

Date: _____ Signature of Proposer _____
Date /Month /Year Rubber Stamp/Seal.

Please do attach a copy of your PIN certificate, National Identification card/Passport and utility bill as per the "proceeds of crime and anti-money laundering Act, 2009 "as" acceptable proof of identity.

Note: Liability does not commence until this proposal has been accepted and premium paid. condition of this policy that Estimated annual Wages, Salaries and other Earnings to be certified annually by your Auditors within three months of the expiry date of the period of insurance.