Group Personal Accident 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. a) What are the highest emoluments paid to any one individual _____

   b) Is every person to be insured in good health and free from any mental defect or infirmity to the best of the proposer's knowledge and belief. Yes ☐ No ☐

   If yes please give details _____

   c) Is any person to be insured suffering from any physical defect or infirmity Yes ☐ No ☐

   If yes please give details _____

   d) Has any of them suffered from GOUT, DIABETES, PARALYSIS or FIT of any kind? Yes ☐ No ☐

   If yes please give details _____

8. Will any of the persons to be insured travel to a considerable extent by air or motor vehicle in the course of his or her duty 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 ☐

   If yes to any of the above, please give details _____

   (Travel by Air shall mean travelling as a passenger in an aircraft operating on scheduled services)

9. Will any of the persons to be insured use machinery? 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 the answer to any of the above is yes, please give details

    _____

    _____

AAR Insurance

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, amount of loss and cause of loss

_____

Schedule A: Insured persons for fixed benefits only

Names of Persons to be Insured	Date Of Birth	Occupation	Benefits Required			
			Death	Permanent Disablement	Temporary Total Disablement	Medical Expenses

Schedule B: Insured persons for benefits based on wages or salaries.

Business or Occupation of Insured	Number	Estimated Gross Total Emoluments Per Annum	Benefits Required			
			Death	Permanent Disablement	Temporary Total Disablement	Medical Expenses

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

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

Agent / Broker: _____ Mobile No. _____

DECLARATION:

I/Wedeclare and warrant that the statements given above are true and complete to the best of my/our knowledge and belief and 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:_____
Date / Month / Year

Signature Of Proposer
Rubber Stamp / Seal

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

NOTE: Liability does not start until this proposal has been accepted by the insurer and first premium paid. It is also a 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.