



PROPORSAL FOR WORKMEN'S COMPENSATION (ACT LIMITS) INSURANCE

Summary of Cover

Indemnity to Employer against legal liability under the Workmen's Compensation in respect of assessments and awards for bodily injury by accident or disease caused to employees occurring during the period of Insurance and arising out of and in the course of that Employment by the Employer in the Business. Subject to the terms, jurisdiction clause, exceptions, conditions and warranties of the Company's Workmen's Compensation (Act Limit) Policy .

Name in full.....
Postal Address..... Telephone No
Business Address.....
Business.....
Particulars of Work.....
Period of Insurance required From.....To.....

All questions must be answered fully .Ticks or Dashes are not sufficient. Please note carefully that the truth of the statements and answers in this proposal are conditions

- 1 Does any law or regulation governing the conduct or maintenance of premises apply to your Premises?
2 (a) Have you any circular saws or machinery driven by steam, gas, water electricity or other mechanical power?
(b) Have you any boilers?
(c) Are your ways works and plant properly fenced and guarded and otherwise in good order and condition?
3. Do you use acids gases chemicals or explosives?
4. Do you handle or use radioisotopes radioactive substances or such sources of ionizing radiations?
5. (a) Are you at present Insured or have you ever proposed for Workmen's Compensation (Act Limits) Policy with the Company?
(b) Are you at present insured or have you ever proposed for any insurance in respect of your legal liability under Common Law to you Employees?
(c) Have such proposals or renewals ever been declined or withdrawn?
(d) Have increased rates been required for such proposal renewals?

SCHEDULE-

ALL PERSONS TO BE INSURED UNDER THE WORKMEN'S COMPENSATION LAWS.

Estimated annual
Wages Salaries &
Other earnings

For use by
Insurers Only

Description of Employees (List each type separately)	Estimated No of Employees	Cash	Value of Food, Fuel Quarters & Other Consideration	Total per mille	Rate	Prem	Classi- fication Number
(a).....							
(b).....							
(c).....							
(d).....							
(e).....							
(f).....							
(g).....							
(h).....							
(i).....							
(j).....							

TOTAL PREMIUM

Please note that it is condition of this Policy that the Estimated Annual Wages, Salaries and other Earnings is required to be certified annually by your Auditors within three months of the Expiry date of the Period of Insurance

7. Give the following information in respect of the past three years.

Year	Wages Salaries & Other Earnings	No of Accidents to your Employees (whether or not involving claims)	CLAIMS			
			Number	Settled Cost	O/Standing Number	Cost
200.....						
200.....						
200.....						

I/We the Undersigned desire to effect an Insurance in terms of the policy to be issued by the Company against my/our liability under Workmen's Compensation Act as above mentioned. I/We agree to keep a proper Wages Book and to render at the end of each period of Insurance a statement in the forms required by the Company of all Wages, Salaries and other earnings which shall be dully certified by our Auditors to pat Premium on any amount in excess of the amount estimated above. I/We have read over and checked are true that I/We have not suppressed or mis-stated any material fact, that I/We have fairly estimated the total amount of wages, salaries and other earnings and I/We agree that this declaration shall be the basis of the contract between me/us and the Company.

Date.....Signature of Proposer