

WORK INJURY BENEFIT INSURANCE

Proposal Form

Paybill: 886835



Agent: _____

EMPLOYER DETAILS

Company/ Trade Name: _____ Nature of business: _____

Registration no: _____ KRA PIN: _____

Postal Address: _____ Postal Code: _____

Town/ City: _____ County: _____

Telephone no: _____ Mobile no: _____ Fax: _____

Email address: _____

WORKPLACE DETAILS

Does any law or regulation governing the conduct or maintenance of premises apply to your premises?

Yes No

If so, name such laws and regulations.

Do you have any circular saws or other machinery driven by steam, gas, water, electricity or other mechanical power?

Yes No

If yes, give details

Do you have any boilers? Yes No

Are your ways, works and plant properly fenced and guarded and otherwise in good order and condition? Yes No

Do you use acids, gases, chemicals or explosives?

Yes No

If yes, give details

Do you handle or use radio isotopes radioactive substances, or other sources of ionising radiations?

Yes No

If yes, give details

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

If yes, give details

Do you have any employees who are apprentices or trainees/interns in your organisation? Yes No

If yes, give details on wages payable

COVER DETAILS

Are you currently covered by UMMA INSURANCE under any other policy? Yes No

Has any insurance company:	Yes	No
Declined your proposal?	<input type="radio"/>	<input type="radio"/>
Canceled or refused to renew your cover?	<input type="radio"/>	<input type="radio"/>
Required an increase on your premium?	<input type="radio"/>	<input type="radio"/>

If yes, please include details

Are you entitled to a No Claim Discount (NCD) from your previous insurer? Yes No

Period of Insurance: From: _____ To: _____

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

Names/ number of employees	Description of Occupation	Estimated Salaries / Wages	Rate	Premium	Classification

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Number of Accidents to your employees (whether or not Involving claims) in the past 3 years

DECLARATION

I/we the undersigned desire to effect insurance in terms of the policy to be issued by the Company against Liability to my/our Employees within the meaning of the Work Injury Benefits Act, 2007. I/we agree to keep detailed records of all persons employed (including Identification documents) and to submit within three months after the end of each period of Insurance a statement in the form required by the Company of all wages, salaries, other earnings, which shall be duly certified by our Auditors and to pay premium on any amount in excess of the amount estimated above.

I/ We do here declare that the information included in the document is true and that
I/ We have not withheld no material or information in this proposal

Date: _____

Signature of the proposer

Rubber stamp/ Seal