

## INSURANCE QUESTIONNAIRE AND PROPOSAL FORM

### 1 General Information:

a) Full name of Proposer:

Reg. No.  Nationality  Year Established

Activity

b) Address: Location	Building:	Street:
	Dist:	City:

P.O. Box  Postal Code

Phone Nos.  Fax No.

Email ID

c) Contact Person 1	Name:	Title:
	Tel. Extn.	Mobile No.
	Email ID:	

Contact Person 2	Name:	Title:
	Tel. Extn.	Mobile No.
	Email ID:	

Contact Person 3	Name:	Title:
	Tel. Extn.	Mobile No.
	Email ID:	

2. **Period of Insurance:**  
From: ...../...../..... To ...../...../.....

3. **Particulars of Work in which the employees will be engaged:**

**Territory(ies) in which workmen are employed:**

4. **All persons engaged in the work must be included:**

Description of Employees	Estimated No. of Employees	Estimated Annual Wages (Salaries and Other Earnings)		
		Cash	Living or Other Allowances	Total
Clerical Staff				
Commercial Travelers				
Employees engaged with wood working machinery, including machinists and machinist laborers				

5. **The total amount of wages, salaries, and other earnings paid by me/us to the above-mentioned employees during the past twelve SR \_\_\_\_\_ months was**

6. **Does the SCHEDULE include all persons in your service?** Yes  No

7. **Have you carried out all the obligations imposed on you by Labor Law and/or Regulations?** Yes  No

8. a) Have you any circular saws or other machinery driven by steam, gas, water, electricity or other mechanical power? Yes  No

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

9. **What boilers do you have?**

10. **State what acids, gases, chemicals or explosives will be used with work and to what extent:**

**11. State hereunder amount of wages paid and give particulars of number of accidents to your employees incidental to their occupation during the past three years:**

Year 1  Total Wages SR

	Settled Claims		Outstanding Claims	
	Number	Cost	Number	Estimated
Death				
Permanent Disablement				
Temporary Disablement				

Year 1  Total Wages SR

	Settled Claims		Outstanding Claims	
	Number	Cost	Number	Estimated
Death				
Permanent Disablement				
Temporary Disablement				

Year 1  Total Wages SR

	Settled Claims		Outstanding Claims	
	Number	Cost	Number	Estimated
Death				
Permanent Disablement				
Temporary Disablement				

12. a) Are you at present insured, or have you ever proposed for insurance in respect of your liability to your employees? Yes  No

If you have, please state the name of the Company

b) Has any such proposal or renewal ever been declined or withdrawn? Yes  No

c) Has an increased rate been required? Yes  No

**We hereby declare that the statements made by us in this Questionnaire and Proposal are, to the best of our knowledge and belief, complete and true, and we hereby agree that this forms the basis and is part of any policy issued in connection with the above risk.**

**It is agreed that the Insurers are liable in accordance with the terms of the Policy only and that the Insured will not lodge any other claims of whatever nature.**

**The Insurers undertake to treat this information in strict confidence.**

**Date:** ..... **Signature of Proposer:** .....