GEMINIA INSURANCE COMPANY LIMITED
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WIBA PLUS (GPA/WIBA)
INSURANCE PROPOSAL FORM

INSTRUCTIONS:
- Please read carefully and fill out the entire document.
- All questions must be answered in full, in BLOCK letters in the applicants own handwriting or dictation.
- Submit a Certificate of Incorporation, KRA pin certificate with this application.

Part 1: WIBA

Indemnity to the employer against legal liability under the Work Injury Benefits Act, 2007 and subsequent amendments in respect of assessments and awards for bodily Injury by accident or diseases caused to employees in course of their employment, and occurring /made during the period of Insurance, subject to the terms, conditions, exceptions and warranties, of the Policy.

Name in full _____

KRA PIN Number _____

Postal Address _____ Postal Code _____

Town _____

Telephone Number(s) _____ Fax Number _____

Email Address _____

Physical Address / Location of premises _____

Nature of Business / Occupation _____

Period of Insurance required: _____

From _____ To _____

(Ensure the Certificate of Incorporation and KRA Pin Certificate copies are attached)

All questions must be answered fully Ticks or Dashes are not sufficient.

Please note that the truth of the statements and answers in the proposal are conditions precedent to liability.

1.(a) 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 _____

_____

2. (a) 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 _____

_____

(b) Do you have any boilers? ☐ Yes ☐ No

If yes, give details _____

_____

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

3. Do you use acids, gases, chemicals or explosives? Yes ☐ No ☐

If yes, give details_____

4. Do you handle or use radioisotopes radioactive substances, or other sources of ionising radiations? Yes ☐ No ☐

If yes, give details_____

5.(a) Are you at present insured or have you ever Proposed for a Workmen's Compensation policy or a work injury benefits policy? Yes ☐ No ☐

If so, please state policy number_____and name the insurers_____

(b) Have such proposals or renewals ever been declined or withdrawn? Yes ☐ No ☐

If so, please give reasons_____

And name of insurer_____

(c) Have increased rates been required for such proposals or renewals? Yes ☐ No ☐

If so, please give details_____

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

Part 2: GROUP PERSONAL ACCIDENT

This section of the policy provides compensation to the Insured should he shall suffer bodily injury, solely and directly caused by accidental, violent, visible and external means, and which shall within twelve (12) calendar months result in death, disablement or the incurring of medical expenses.

a. Do you suffer from any sight, hearing or any other impairment? Yes ☐ No ☐

If yes, please specify_____

b. Have you ever suffered from any serious injury or illness? Yes ☐ No ☐

If yes, please give details_____

c. Are you at present in sound health and free of any physical defects, disability or infirmities? Yes ☐ No ☐

If yes please give details_____

d. Do you engage in hazardous sporting activities or past times? Yes ☐ No ☐

If yes please specify_____

e. Are there any circumstances relating with your occupation, health conditions, habits, past times and pursuits which would increase the risk of accident or bodily injury to yourself? Yes ☐ No ☐

If yes please specify_____

List of Hazardous Sporting Activities or Past Times

Aqualung diving, boxing, climbing or mountaineering necessitating the use of ropes or guides, football (except amateur football), hang gliding, wild hunting, ice hockey, motor racing, motorcycle cycle racing, parachuting, polo, potholing, power boating, racing other than on foot, rugby, show jumping, ski-ing or sledging, water skiing , ice skating, winter sports, wrestling including judo, karate and any other unarmed combat, Yachting outside territorial waters and other hazardous occupations/activities.

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

Names/number of employees	Description of occupation	Estimated annual salaries/wages and Other Earning On Which Premium Is Based

For additional occupations please use a supplementary sheet. The Maximum Age Limit allowed in the policy is 70 Years.

Please note that it is a 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.

Year	Wages, Salaries and other earnings	No of accidents to your employees (whether or not involving claims)	Claims Settled		Claims Outstanding	
			Number	Cost	Number	Cost

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 thirty days 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 hereby declare that all the above statements and particulars are true and I/we have not suppressed, misrepresented or incorrectly stated any material fact, and 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.

PART 3. DECLARATION

I/We do hereby declare that to the best of my knowledge and belief that the statements set forth herein are true and complete. Further, no material facts have been missed or misrepresented. I/we agree that the proposal together with any other information supplied shall form the basis of any contract of insurance effected thereon.

Name of person Completing the Proposal form _____

Designation _____ Date _____

Signature _____

NOTE:

1. The Insured shall accept a policy subject to excesses, restrictions, terms & conditions Geminia Insurance Company Limited may deem necessary.
2. The Insured undertakes to inform the insurer of any material alteration whereby the risk has increased and the insured reserve the right to modify the terms of the policy.