PIONEER GENERAL INSURANCE LTD.

WORK INJURY BENEFITS & EMPLOYER'S LIABILITY INSURANCE PROPOSAL FORM

PIONEER GENERAL
Your Security For The Future

M-PESA Paybill Business No: 100500 **Account No.** _____ **Policy No.** _____

Period of Insurance: From: _____ To: _____

Agency / Broker: _____

SUMMARY OF COVER:

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: _____

Pin Number: _____

Postal Address: _____ Postal Code: _____ Town: _____

Telephone Number(s): _____ Mobile No.: _____

Email Address: _____ Physical Address/Location: _____

Nature of Business/Occupation: _____

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?	(i) Yes/No …… If so, name such laws and regulations. _____ _____ _____ (ii) Have you carried out all obligations imposed on you by such laws and regulations? Yes/No
2. (a) Do you have any circular saws or other machinery driven by steam, gas, water, electricity or other mechanical power? (b) Do you have any boilers? (c) Are your ways, works and plant properly fenced and guarded and otherwise in good order and condition?	(a) Yes/No _____if yes, give details _____ _____ (b) Yes/No _____if yes, give details _____ _____ (c) Yes/No……

3. Do you use acids, gases, chemicals or explosives?	Yes/No _____ If yes, give details _____ _____
4. Do you handle or use radio isotopes radioactive substances, or other sources of ionizing 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? (b) Have such proposals or renewals ever been declined or withdrawn? (c) Have increased rates been required for such proposals or renewals?	(a) If so, please state policy number _____ _____ and name of Insurer(s)_____ _____ (b) If, so please give reasons _____ and name of Insurer(s) _____ (c)Yes/No _____ If yes, give details_____
6. Do you have any employee with pre-existing medical condition?	Yes/No _____
7. (a) Do you have any employees who are apprentices or trainees in your organization?	Yes/No _____ If Yes State how many _____ and give the estimated annual wages payable to a similar person(s) with five years' experience …….. …… ….....

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	USE BY INSURER ONLY		
			Rate	Premium	Classification

For additional occupations please use a supplementary sheet.

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.

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

Year	Wages, Salaries and Other Earnings	Number of Accidents to your employees (whether or not Involving Claims)	Claims			
			Settled		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 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 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.

Signing this proposal form does not bind the proposer or underwriter to accept this insurance.

Executed at this _____ day of _____ 20 _____

For and on behalf of:

Name: _____

Signature: _____
(If Corporate): Name & Designation of Contact Person

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EMPLOYERS LIABILITY

LIMITS OF LIABILITY

Select any one of the following options:

	Any one person	Any one occurrence	Any one year
Option A ☐	500,000	2,500,000	5,000,000
Option B ☐	1,000,000	5,000,000	10,000,000
Option C ☐	2,000,000	10,000,000	20,000,000
Option D ☐	4,000,000	25,000,000	UNLIMITED

BRANCH NETWORK