FIRST ASSURANCE COMPANY LIMITED
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PROPOSAL FORM FOR WORKMEN'S COMPENSATION (ACT LIMITS) INSURANCE

Proposer's Name in full _____

Postal Address _____ Postal Code _____ Town _____

Business or Profession _____

Particulars of Work _____

Period of Insurance required Form _____ 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 the Proposal are conditions precedent to any liability of the Company to make any payment under the Policy.

1.(a) Does any law or regulation governing the conduct or maintenance of premises apply to your premises?	(a) If so, name such laws and regulations. _____ _____ _____ (b) Have you carried out all obligations imposed On you by 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? (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 _____if yes, give details _____ _____
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 ionising raditions?	Yes/No _____ If yes, give details _____ _____
5.(a) Are you at present insured or have you ever Proposed for a Workmen's Compensation Policy with any 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 your employees? (c) Have such proposals or renewals ever been Declined or withdrawn? (d) Have increased rates been required to such proposal or renewals?	(a) If so, please state policy number _____ _____ and name of Insurer(s)_____ _____ (b) If, so please state policy number _____ _____ and name of Insurer(s)_____ _____ (c)Yes/No _____ If yes, give details_____ (d) Yes/No _____ If yes, give details_____

SCHEDULE OF EMPLOYEES TO BE INSURED

Estimated Annual Wages Salaries & Other Earnings				For Official Use Only			
Description of Employees (List each type separately)	Estimated No. of Employees	Salary	Allowances of a constant nature	Total	Rate	Premium	Classification
TOTAL PREMIUM							

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 our employees (whether or not Involving Claims)	Claims			
			Settled		Outstanding	
			Number	Cost	Number	Cost

I/we the undersigned desire to effect an insurance in terms of the Policy to be issued by the Company against my/our common law liability 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 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 which I/we have not suppressed, misrepresented or mis-stated any material fact, that I/we have fairy 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.

Signature: _____ Date: _____