

BAHAMAS FIRST GENERAL INSURANCE COMPANY LIMITED

EMPLOYERS' LIABILITY INSURANCE PROPOSAL

AGENCY: _____

UNDERWRITER: _____

PLEASE GIVE A DEFINITE REPLY TO EACH QUESTION ON THE FORM

No Insurance is in force until the proposal has been accepted by Bahamas First General Insurance Company Ltd.

1. Name: _____			
Postal Address: _____		E-mail Address: _____	
Telephone Nos.	Work _____	Home _____	Cell _____
Trade or Business: _____			
Period of Insurance: From: _____ To: _____			

All Employees must be included

Employees		Payments	Rate per cent.	PREMIUM
Description	No.			
a) Clerical and Managerial Staff who do not engage in manual Labour				
b) Machinists and their Labourers engaged with wood-working machinery driven by mechanical power other than (c) below				
c) Workers whose work with Wood-working machinery is restricted to the use of Lathes, Fretsaws, Boring Machines, Sanding Machines and Mechanically driven Portable Tools applied to the work by hand other than Pendulum and Swing Saws				
d) Shop Assistants, including Delivery hands				
e) Cleaners				
f) Other Employees (give description)				
Total		Total Premium		

*The term "payments" means the total remuneration including overtime, value of board and lodging, housing accommodations, bonuses and other prerequisites in kind or money received by all persons working on behalf of the proposer.

If you wish to insure your liability to the workmen of sub-contractors please complete the following section:-

Name of Contractor	Nature of Work	If contract for labour and materials state estimated amount of contract	In cases for which the contract is for labour only state amount of contract	Rate per cent.	PREMIUM

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IMPORTANT – PLEASE GIVE A DEFINITE ANSWER TO EACH QUESTION AND TICK APPROPRIATE BOX

GENERAL: To be completed by all proposers in full	
1. Does the above Schedule of this proposal include (a) all persons in your employ? (b) all your sub-contractors' employees?	a) Yes <input type="checkbox"/> No <input type="checkbox"/> b) Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you complied with all statutory requirements and other regulations applicable to the business?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Do any of your employees work with circular saws or other machinery driven by steam, gas, water, electricity or other mechanical power? If "YES" please give particulars	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Are your machinery, plant and ways properly fenced and guarded and otherwise in good order and condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Do any of your employees work near any boilers? If YES" please give details	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Will any of your employees work with or near any acids, gases, chemicals or explosives? If "YES" please give details	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Do any of your employees work with a) loading & unloading ships? b) power presses, power rollers or injection moulding machines? c) aircraft or at the airport	a) Yes <input type="checkbox"/> No <input type="checkbox"/> b) Yes <input type="checkbox"/> No <input type="checkbox"/> c) Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Are you at present insured or have to ever proposed for an insurance in respect of your liability to your employees? If "YES" please give details	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Has any company or Underwriter at any time: a) Declined to accept or continue any insurance of yours? b) Required an increased premium or imposed special conditions? If "YES" please give details	a) Yes <input type="checkbox"/> No <input type="checkbox"/> b) Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Have you any other insurances with Bahamas First General Insurance Co.?	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Policy Nos. (if any) to be cancelled	Yes <input type="checkbox"/> No <input type="checkbox"/>

12. State amount of wages paid and give particulars of numbers of accidents to your employees incidental to their occupation during the past 3 years

Year	WAGES	FATAL		PERMANENT DISABLEMENT		TEMPORARY DISABLEMENT ONLY	
		Number	Compensation paid to date	Number	Compensation paid to date	Number	Compensation paid to date
CLAIMS OUTSTANDING		Number	Estimated further cost	Number	Estimated further cost	Number	Estimated further cost

Important Note: All material facts must be disclosed. Failure to do so may invalidate the policy. A material fact is one which is likely to influence an Insurer in the assessment and acceptance of the proposal. If there is any doubt as to whether or not a fact is material it should be disclosed to the Insurer.

Declaration:

I/We agree that a) to the best of my/our knowledge and belief all statements and particulars contained in this proposal are true, and b) this proposal and declaration shall form the basis of the contract between me/us and the Insurer.

Date Proposer's Signature