



Tausi Assurance Company Limited

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EMPLOYERS LIABILITY (COMMON LAW) INSURANCE PROPOSAL FORM.

The issuing of this form is not to be taken as an admission of liability by the Insurers.

NB: All questions must be answered in full. Dashes are not acceptable. Please use **BLOCK LETTERS** and tick where appropriate.

SUMMARY OF COVER

Indemnity to the employer against legal liability under common law for damages and claimants costs and expenses of litigation in respect of awards for bodily injury by accident or disease caused to employees during the period of insurance and arising out of and in the course of that employment by the Employer in the Business and directly related to breach of common law or statutory duty by the Employer and in addition indemnity in respect of all costs and expenses incurred by the Employer with the Company's written consent subject to the terms, jurisdiction clause, exceptions, conditions and warranties of the Company's Employers Liability (Common Law) Policy.

PARTICULARS OF PROPOSER

1. Name of the Proposer (in full)

Postal Address

P.O Box:

Code:

Town:

Telephone Contact

Email Address

Pin No

(Attach copy of the certificate)

ID/Passport Number

(Attach copy of the certificate)

Certificate of Incorporation Number

(Attach copy of the certificate)

Physical Address/Location

Profession/Occupation

Period of Insurance:

From:

To:

2. 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

b) Have you carried out all obligations imposed on you by such laws and regulations?

☐ YES

☐ NO

If No, state why

3. a) Do you have any circular saws or other machinery driven by steam, gas, water, electricity or other mechanical power?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If Yes, give details		
b) Do you have any boilers?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If Yes, give details		
c) Are your ways, works and plant, properly fenced and otherwise in good order and condition?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If Yes, give details		
4. Do you use acids, gases, chemicals or explosives?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If Yes, give details		
5. Do you handle or use radioisotopes, radioactive substances, or other sources of ionizing radiations?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If Yes, give details		
6. a) Are you presently insured for Work Injury Benefits?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If Yes, please state policy number and name of Insurer(s)		
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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If Yes, please state policy number and name of Insurer(s)		
c) Have such proposals or renewals ever been declined or withdrawn?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If Yes, please give reasons and name of Insurer(s)		
d) Have increased rates been required for such proposals or renewals?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If Yes, give details		
7. Do you have any employee with pre-existing medical conditions?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If Yes, give details		

8. Do you have any employees who are ☐ YES ☐ NO

apprentices or trainees in your organization?

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.

			For official use only		
Names/number of employees	Description of Occupation	Estimated Annual Salaries/Wages And Other Earning On Which Premium Is Based	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 Auditor within three months of the expiry date of the period of Insurance.

9. 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

10. LIMITS OF LIABILITY

Please state the option selected A B C or D (CIRCLE THE OPTION REQUIRED)

<u>OPTIONS</u>	A	B	C	D
Limits of Liability				
Any one person	Kshs. 2,000,000	Kshs. 4,000,000	Kshs. 6,000,000	Kshs. 8,000,000
Any one occurrence	Kshs. 10,000,000	Kshs. 15,000,000	Kshs. 20,000,000	Kshs. 25,000,000
Any one year	Kshs. 20,000,000	Kshs. 30,000,000	Kshs. 40,000,000	Kshs. 50,000,000

Declaration

I/We hereby declare that the statements made by me/us in this Questionnaire and Proposal form are, to the best of my/our knowledge and belief, complete and true, and I/We hereby agree that this Questionnaire and Proposal form, forms the basis and is part of any policy issued in connection with the above risk(s). It is agreed that the Insurers are liable in accordance with the terms of policy only and that the insured will not lodge any other claims of whatever nature.

The insurers undertake to deal with this information in strict confidence.

The liability of the company does not commence until the proposal has been accepted and the first premium paid.

Executed at this

day

of 20

For and on behalf of:

Name:

Signature and Official Stamp

Name and Designation of Contact Person:

Telephone of Contact Person:

AGENT/BROKER NAME / STAMP**SIGNATURE****DATE**