"A Symbol of Trust, Security and Progress"

Tausi Assurance Company Limited

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WORK INJURY BENEFITS 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 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 the course of their employment, and made during the period of insurance subject to the limits, terms, conditions, exceptions and warranty of the policy, a brief summary of which is given here below:

	Cover	**Compensation (Per Employee)**
(a)	Death	96 months earnings (Maximum: Kshs. 4,000,000/=)
(b)	Permanent Total Disability	96 months earnings (Maximum: Kshs. 4,000,000/=)
(c)	Temporary Total Disability (Kshs. 4,000,000/=)	Actual weekly earnings for twelve months.
(d)	Medical Expenses	Maximum: Kshs 100,000/= per person
(e)	Funeral Expenses	Maximum: Kshs 30,000/= per person

Geographical Area: - Kenya only		
	Limit of Company's Liability	
(a)	Any one person	Kshs. 4,000,000/=
(b)	Any one occurrence	Kshs. 25,00000/=
(c)	Any one year	Kshs. 50,000,000/=
Excess: Kshs. 5,000/= each and every claim, excluding claims for funeral expenses		

Policy Exceptions:	
1)	Any liability not provided for in the Work Injury Benefit Act.
2)	Any accidental death or injury occurring outside normal working hours.
3)	Liability attaching solely by virtue of an agreement.
4)	Injury by accident or disease outside the Geographical area by any employee whose contract is Not made in Kenya or subject to Laws of Kenya.
5)	Injury by accident or disease sustained by any employee who is below sixteen years.
6)	Willful misconduct of the employee.
7)	Liability arising out of any court proceedings

8) Liability arising out of pre-existing medical condition.
9) Any amount recoverable from any party which cannot be recovered due to an agreement between the Injured and such party.
10) Business or occupation other than described in the schedule
11) Injury by accident or disease due to war, invasion, act of foreign enemy, civil war, mutiny, rebellion, revolution, terrorism
12) Diseases referred to as: (i) Pneumoconiosis. (ii) Asbestosis. (iii) Silicosis. (iv) Byssinosis. (v) Any disease which is brought under the provisions of the Work Injury Benefit Act specified in the second schedule
13) Any liability due to nuclear weapons, ionizing radiation or contamination

Policy Conditions
1) Insured is to take all reasonable precautions to prevent accidents or disease and will comply with all statutory obligations.
2) Insured will not make any admission on liability or offer any payment without the written consent of the Company
3) In the event of double insurance, this company will pay for its rate-able proportion only
4) Insured will submit the actual wages with full details certified by the Auditors within three months of expiry of the policy.
5) Insured is expected to keep full and proper records of all employees for at least six years
6) Insured shall comply with legal Notice No: 31 of 2004 and establish Safety and Health Committee when employing twenty or more persons.
7) The policy will provide cover for transportation of employees owned/hired by Insured to/from officially designated places of work and in course of employment/social recreational/sporting activity provided the vehicles conform with the Traffic Act Cap 403.
Note:- The foregoing is a brief of the standard policy terms and for proper reference the actual policy document must be read. Also, the term, conditions, exceptions or warranties of the policy may be altered or amended based on the underwriting information or disclosure of material facts in the proposal form. Nothing in this summary will supersede the contents of the actual policy document

PARTICULARS OF PROPOSER – WIBA SECTION			
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)
Physical Address/Location			
Profession/Occupation			
Certificate of Incorporation No.			(Corporate - Attach copy of the certificate)
Period of Insurance required	From:	To:	

1. Does any law or regulation governing the conduct or maintenance of premises apply to your premises?	☐ **YES**	☐ **NO**
	If Yes, name such laws and regulations.	
Have you carried out all obligations imposed on you by such laws and regulations?	☐ **YES**	☐ **NO**
2. Do you have any circular saws or other machinery driven by steam, gas, water, electricity or other mechanical power?	☐ **YES**	☐ **NO**
	If Yes, please give details	
Do you have any boilers?	☐ **YES**	☐ **NO**
	If Yes, please give details	
Are your ways, works and plant properly fenced and guarded and otherwise in good order and condition?	☐ **YES**	☐ **NO**
	If Yes, please give details	
3. Do you use acids, gases, chemicals or explosives?	☐ **YES**	☐ **NO**
	If Yes, please give details	
4. Do you handle or use radio isotopes, radioactive substances, or other sources of ionizing radiations?	☐ **YES**	☐ **NO**
	If Yes, please give details	
5. 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 Yes, please give details	
Have such proposals or renewals ever been declined or withdrawn?	☐ **YES**	☐ **NO**
	If so, please state policy number and name of Insurer(s)	

Have increased rates been required for such proposals?	☐ **YES**	☐ **NO**
	If Yes, please give details	
6. Do you have any employee with pre-existing medical condition(s)?	☐ **YES**	☐ **NO**
7. 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.

			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 Auditors within three months of the expiry date of the period of Insurance and submitted to the Insurance Company.

Give the following information in respect of the past three year

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

PARTICULARS OF INSURANCE

1. Have any office of an Insurance Company or Underwriter ever?

(a) Cancelled your policy? ☐ **YES** ☐ **NO**

(b) Declined to Insure you? ☐ **YES** ☐ **NO**

(c) Declined to renew your Policy? ☐ **YES** ☐ **NO**

(d) Imposed any special terms? ☐ **YES** ☐ **NO**

(e) Repudiated any claim? ☐ **YES** ☐ **NO**

If the answer to any of the above reasons is yes, please give details:

2. Has any Insurer ever declined the cover or imposed special terms? ☐ **YES** ☐ **NO**

If yes, give details

CLAIMS EXPERIENCE

1. Have any employees covered under Group Accident Cover suffered any accidents in the last 5 years? ☐ **YES** ☐ **NO**

If so, give particulars of each accident as under:

Date of Accident	**Nature of Claim**	**Compensation Amount Received**	**Name of Company which paid the Claim**

IF THE SPACE IS NOT SUFFICIENT ATTACH PAPER WITH DETAILS

BENEFITS REQUIRED

1. Benefits - State amount to be Insured under each heading in Kenya Shillings

IMPORTANT NOTE

Weekly Benefit should not exceed 75% of weekly income

Name of Persons to be Insured (Mr/Mrs/Ms)	Occupation	Death and/or Permanent Total Disablement **Benefit A**	Temporary Total Disablement(per week) **Benefit B**	Medical Expense Limit **Benefit C**	Premium

ATTACH SEPARATE SHEET IF SPACE IS NOT SUFFICIENT

2. Group Personal Accident cover required

(a) 24 hour basis? ☐ **YES** ☐ **NO**

(b) Occupational Risks only? ☐ **YES** ☐ **NO**

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**