INSURANCE COMPANY (JAMAICA) LIMITED

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EMPLOYER'S LIABILITY PROPOSAL FORM

Policy Number _____ Broker/Agent _____

INSURED'S NAME _____

TRADE OF BUSINESS _____

TAXPAYER REGISTRATION NUMBER.(TRN) _____

REGISTERED ADDRESS _____

MAILING ADDRESS _____

TELEPHONE NO.(S) _____ FAX NO. _____ EMAIL ADDRESS _____

DETAILS OF CONTACT PERSON

MR./MRS./MS./ DR./ OTHER _____ FIRST NAME _____ LAST NAME _____

TELEPHONE NO. _____ EMAIL ADDRESS _____

ARE ANY OF YOUR OFFICERS INVOLVED OR ASSOCIATED WITH ANYONE HOLDING ANY PROMINENT PUBLIC POSITION SUCH AS AN OFFICIAL OR EXECUTIVE OF A POLITICAL PARTY, SENIOR POLITICIAN OR SENIOR GOVERNMENT?

☐ YES ☐ NO

IF YES, PLEASE STATE ONE OR THE OTHER

_____

_____

IN RESPECT OF PRINCIPAL OWNERS, DIRECTORS & BENEFICIARIES;

Title	Name	Address

Attach a supplementary sheet, if necessary

WE ALSO REQUEST THAT YOU SUBMIT THE FOLLOWING DOCUMENTS:

- CERTIFICATE OF INCORPORATION (OR SIMILAR DOCUMENT APPROPRIATE FOR BUSINESS)
- MEMORANDUM AND ARTICLE OF ASSOCIATION (OR ARTICLES OF INCORPORATION)
- MOST RECENT ANNUAL RETURNS FILED WITH THE COMPANIES OFFICE OF JAMAICA AND RECEIPT FOR THE FILING FEE. NAME(S) & ADDRESS(ES) OF OWNER(S) WITH SHAREHOLDINGS OF 10% OR GREATER.
- COPIES OF ID FROM AT LEAST TWO (2) DIRECTORS. WE ALSO ACCEPT ANY IDENTIFICATION WITH A PHOTOGRAPH SUCH AS PASSPORT, DRIVER'S LICENCE, AND ELECTOR REGISTRATION ID CARD
- SIGNED DIRECTOR'S STATEMENT AS TO THE NATURE OF THE COMPANY'S BUSINESS.

COVER

(A) In respect of all employees, indemnity against your liability at LAW other than under the Workmen's Compansation Laws. (Please complete Schedule 'A' below. All employees must be included).

OPTIONAL ADDITIONAL COVER

(A) In respect of all employees, within the scope of the Workmen's Compensation Laws, indemnity against your liability Under such laws:
Workmen's Compensation Law Cap 418 and Workmen's Compensation (Amendment) Laws of 1954 and 1960.

(If this insurance is required please complete schedule 'B' below. All such employees must be included)

Description of Employees	Estimated No. of Employees	Estimated Annual Wages/Salaries and Other Earnings
SCHEDULE 'A'		
Managerial/Clerical		
Supervisors		
Drivers		
Employees engaged with food working machinery including machinists		
Labourers		
Contracted Employees		
Others		
SCHEDULE 'B'		

Limit of Indemnity Required $ _____

Do you wish to insure your liability under the Workmen's Compensation Legislation of the workmen of sub-contractors (i.e. of "Contractors" as defined in the legislation) This cover only applies to such of the sub-contractors employees as are workmen with the scope of the Workmen's Compensation Legislation.

If so, please state -

Names of Contractor (s)	**Name of work sublet**	**Total Earnings of Contractors Workmen**

1. Does Schedule 'A' above include all persons in your service? ○ YES ○ NO _____

2. If the insurance is to extend to employees within the scope of Workmen's Compensation Legislation, does Schedule 'B' above include all such persons in your service?

_____

3. Do your premises come within the meaning of any Law and/or Regulation governing the conduct or maintenance of such premises? ○ YES ○ NO

a. If so, name such Laws and Regulations? _____

_____

b. Have you carried out all the obligations imposed on you by such Laws and/or Regulations? ○ YES ○ NO

4. Have you any circular saws or other machinery driven by stream, gas, water, electricity or other mechanical power? ○ YES ○ NO

If so, give full particulars. _____

b. Are your machinery, plant and ways properly fenced and guarded or otherwise in good order and condition? ○ YES ○ NO

5. What boilers have you? _____

6. State what acids, chemicals or explosives will be used and to what extent: _____

_____

7. Do you handle or use radioisotopes, radioactive substances or other sources or ionizing radiations? ◯ YES ◯ NO

8. State hereunder amount of wages paid and give particulars of number of accidents to your employees incidentally to their occupation during the past three years:

Year	Wages	Number of	Fatal (Compensation paid to date)	Number of	Permanent Disablement (Compensation paid to date)	Number of	Temporary Disablement Only (Compensation paid to date)
Year	**Wages**	**Number of**	**Cliams still unsettled (Estimate further cost)**	**Number of**	**Claims still unsettled (Estimate further cost)**	**Number of**	**Claims still unsettled (Estimate further cost)**

9. Are you at present insured, or have you ever proposed for insurance in respect of your liability to your Employees? ◯ YES ◯ NO

If so, please state Name of Company: _____

a. Has any such Proposal or Renewal ever been declined or wthdrawn? ◯ YES ◯ NO _____

b. Has an increased rate been required? ◯ YES ◯ NO _____

Period of Insurance Required

From _____ To _____

Declaration

I/We the undersigned, desire to effect insurance as above stated in terms of the policy to be issued by the Company. I/We agree to keep a proper Wages Record and to render at the end of each Period of Insurance a statement in the form required by the Company of all wages actually paid and to pay premium on any wages paid in excess of the amount estimated above. I/We have hereby declare that all statements and particulars which I/We have read over and checked are true, and I/We have not suppressed, misrepresented, or misstated any material fact, and I/We have fairly estimated my/our total wages and salaries expenditure and I/We agree that this declaration shall be the basis of the contract between me/us and the company.

Date _____ Signature _____

Extra Benefits (applicable to cover B only)

1. (a) Payment of Compensation under the Workmen's Compensation Laws from the date of incapacity.

   (b) Payment of Compensation under the Worksmen's Compenstion Laws from the date of incapacity where the incapacity does not exceed 3 consecutive days.

2. Inclusion of Medical Expenses incurred by the Employer.

State what Extra Benefits are to be included: _____

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Revised: June 22, 2022