

## **INSURANCE COMPANY (BARBADOS) LIMITED**

Suite 8, Dome Mall, Warrens, St. Michael BB22026 Telephone: 246-538-2200 Email: infobb@genac.com

# EMPLOYER'S LIABILITY PROPOSAL FORM

Policy Number		Broker/Agent				
INSURED'S NAME						
TRADE OF BUSINESS						
TAXPAYER REGISTRATIO	N 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 SUCH AS AN OFFICIAL OR EX	S INVOLVED OR ASSOCIATED WITH ANY XECUTIVE OF A POLITICAL PARTY, SENIC	ONE HOLDING ANY PROMINENT PUBLIC POSITION,  YES POLITICIAN OR SENIOR GOVERNMENT?	NO			
IF YES, PLEASE STATE ONE OR T	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 CORPORATE REGISTRY OFFICE OF BARBADOS
- 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 OR DRIVER'S LICENCE

#### COVER

(A) In respect of all employees, indemnity against your liability at LAW. (Please complete Schedule 'A' below. All employees must be included).

Description of Employees		Estimated	Estimated No. of Employees Estimated			d Annual Wages/Salaries and Other Earnings		
CHEDULE	'A'							
	Managerial/Cler	rical						
	Supervisors							
	Drivers							
Employees	s engaged with food w including machir		nery,					
	Labourers							
	Contracted Emplo	oyees						
	Others							
Limit of Inden	nity Required \$							
. Does Sched	ule 'A' above include	all persons in	your service? 🔲 YES	NO	)			
. Do your pre	mises come within th	e meaning of a	any Law and/or Regulation	on governin	ig the conduct of	or maintenance o	f such premise	es? YES NO
a. If so, nam	ne such Laws and Reg	gulations?						
b. Have vou	carried out all the ob	ligations impo	osed on you by such Law	s and/or Re	gulations?	YES	NO	
-	-	her machinery	driven by steam, gas, w	ater, electri	city or other me	echanical power?	YES	S NO
If so, give fu	all particulars							
b. Are your	machinery, plant and	ways properly	fenced and guarded or o	otherwise in	good order and	d condition?	YES	NO
4. What boiler	s have you?							
5. State what a	cids, chemicals or exp	plosives will b	be used and to what exten	ıt				
. Do you hand	dle or use radioisotop	es, radioactive	substances or other sour	rces or ioniz	radiations?	YES	NO	
7 State hereur	der amount of wages	naid and give	particulars of number of	Pagaidants t	o vour employe	as incidentally t	o their occups	tion during the past three years:
. State hereur	ider amount of wages	paid and give	particulars of number of	accidents t	o your employe	tes incluentany t	o men occupa	tion during the past three years.
			Fatal		Permanent	Disablement	Number	
Year	Wages	Number of	(Compensation paid	Number of	(Compensa	ation paid to	of	Temporary Disablement Only (Compensation paid to date)
			to date)		da	ate)		(•••••••••••••••••••••••••••••••••••••
		Number	Claims still unsettled	Number	Claims st	till unsettled	Number	Claims still unsettled
Year	Wages	of	(Estimate further	of		further cost)	of	(Estimate further cost)
			cost)					

8. 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				
<b>Declaration</b> 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 declared 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.

Signature

Date

Extra Benefits (applicable to cover B only)

Inclusion of Medical Expenses incurred by the Employer.

State what Extra Benefits are to be included.

Print Form

Revised: November, 2020