RESOLUTION INSURANCE

Summary of Cover:
Indemnity to the employer against legal liability under the Work Injury Benets Act, 2007 and subsequent amendments in respect of assessments and awards for bodily Injury by accident or diseases caused to employees in course of their employment, and occurring /made during the period of Insurance, subject to the terms, conditions, exceptions and warranties, of the Policy.
(**Note**: Please complete all sections in Block letters and **BLACK** ink)

A: DETAILS OF ORGANIZATION

Name of Company/Organization

Describe the nature of business

Telephone Number (Code / Number) Alternative Number (Code / Number)

Email Address PIN No.

Postal Address (Number / Postal Code / Town)

Physical Address (Building / Floor / Street / Town)

Period of Insurance required From D D M M Y Y Y Y To D D M M Y Y Y Y

CONTACT PERSON

Name (Surname / First Name / Middle Name)

Designation

Email

Telephone Number (Code / Number) Mobile Number (Code / Number)

B: BENEFITS & EXPERIENCE

Please note that the truth of the statement and answers in the proposal are conditions precedent to liability

1. Does any law or regulation governing the conduct or maintenance of premises apply to your premises? Yes ☐ No ☐

   If 'yes', Name such laws _____

   (ii) Have you carried out all obligations imposed on you by such laws and regulations? Yes ☐ No ☐

2. Do you handle or use radio isotopes radioactive substances, or other sources of ionizing radiations? Yes ☐ No ☐

   If 'yes', give details _____

3. (a) 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 state policy number _____ and name of Insurer(s) _____

   (b) Have such proposals or renewals ever been declined or withdrawn? Yes ☐ No ☐

   If 'yes', please give reason and name of insurer? _____

   (c) Have increased rates been required for such proposals or renewals? Yes ☐ No ☐

   If 'yes', please give details _____

4. Do you have any employee with pre-existing medical condition? Yes ☐ No ☐

   If 'yes', how many _____

5. Do you have any employees who are apprentices or trainees in your organization? Yes ☐ No ☐

If 'yes', how many _ _ _ _ _ _ _ _ _ and give the estimated annual wages payable to a similar person(s) with five years experience _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Description of employees (list each type separately)	Estimated annual wages, salaries and other earnings				For use by Insurer only		
	Estimated No. of employees	Cash (Kshs)	Value of food, fuel, accommodation and other consideration (KShs)	Total (Kshs)	Rate per mile	Premium (Kshs)	Classification No.
						Total Premium (Kshs)	

***Note:* EMPLOYEES BEING WORKERS AS DEFINED BY SECTION 5 OF THE WORK INJURY BENEFITS ACT, 2007**

Please note that it is a condition of this Policy that the Estimated Monthly Wages, Salaries and other Earnings of all employees be declared. Any under-declaration either of the number of employees or the earnings may results in resultant claim being declined.

Year	Wages, salaries and other earnings (KShs)	No. of accidents to your employees (whether or not involving claims)	CLAIMS			
			Settled		Outstanding	
			Number	Cost (KShs)	Number	Cost (KShs)

Benefits (Please tick where appropriate)

A. WIBA ☐ B. WIBA Plus ☐ C. Political Violence & Terrorism Extension ☐

C: DECLARATION

I/we the undersigned desire to effect insurance in terms of the policy to be issued by the Company against Liability to my/our Employees within the meaning of the Work Injury Benefits Act, 2007. I/we agree to keep detailed records of all persons employed (including Identification documents) and to submit within thirty days after the end of each period of Insurance a statement in the form required by the Company of all wages, salaries, other earnings, which shall be duly certified by our Auditors and to pay premium on any amount in excess of the amount estimated above. I/we hereby declare that all the above statements and particulars are true and I/we have not suppressed, misrepresented or incorrectly stated any material fact, and that I/we have fairly estimated the total amount of Wages, salaries and other earnings and I/we agree that this declaration shall be the basis of the contract between me/us and the Company.

Signing this proposal form does not bind the proposer or underwriter to accept this insurance.

Executed at this D D M M Y Y Y Y

AUTHORIZED SIGNATORY

Name

Designation

Signature

Date

OFFICIAL STAMP

For Official Use

Amount (Ksh)	
Total	

Full Name of Agent/Broker

Account Manager

Telephone Number — Code — Number

Agent/Broker

Name: ..... **Telephone:** .....