GROUP PERSONAL ACCIDENT INSURANCE PROPOSAL

Submission Date: _____

Quote Due Date: _____

RISK INFORMATION

Name: _____

Street Address: _____

City: _____

Telephone Number: ( ) _____ Fax Number: ( ) _____

Nature of Business: _____ Country: _____

Total Number of Employees: _____ Total Number of Employees To be Covered: _____

Eligibility (Define): _____

Please supply an employee detail (by Location) in the chart. Attach another sheet, if necessary. If detail is not possible, complete the first line.

Location	Class I	Class II	Class III	Class IV	Number of Covered Employees

BENEFIT SCHEDULE

Accidental Death & Dismemberment: Rs.

Permanent Total Disability : Rs.

Permanent Partial Disability : Rs.

Deductible: : Rs. Primary ☐ or Excess ☐

WEEKLY ACCIDENT INDEMNITY

Maximum Weekly Amount : Rs. _____

Elimination Period : _____

Maximum Duration : _____

Other requested Benefits : _____

Aggregate limit per occurrence: Rs. _____

WHAT IS MONTHLY VOLUME OF INSURANCE

What is the principle sum per class? Rs. _____

If multiple of earnings how is salary defined? _____

What is the highest salary? Rs. _____

Average Salary? Rs._____

Please Note: The Standard Age Reduction Schedule will apply. This reduces the benefits applicable to employees over age 69. Please attach a list of individuals over age 65 (including Class and date of birth) only if Full Benefits for those employees over age 65 are to be maintained.

COMPANY AIRCRAFT INFORMATION

Does the company (or any subsidiary/division) own, lease, or operate aircraft?

❑ Yes ❑ No If Yes, complete the chart below.

Please note any other appropriate details about aircraft: _____

Year	Make	Model	Serial Number	Seating Capacity		Average Usage
				Passenger	Crew	

Is piloting coverage to be provided? ❑ Yes ❑ No

If Yes, is piloting coverage for the company aircraft only? ❑ Yes ❑ No

Please Note: Pilot history forms will have to be completed if pilots are to be covered.

UNUSUAL OR HAZARDOUS EXPOSURES

Are there any unusual or hazardous exposures to be covered? ❑ Yes ❑ No

If Yes, please describe: _____

_____

PRIOR COVERAGE

Insurance Company Name: _____

Effective Date: _____ Renewal Date: _____

Please attach all available details of current program, including coverage, benefits, limits provided, Summary Plan Description, copies of policies, a minimum of three (3) years' premium and loss experience, as well as rate history.

Please tell us about your organization.

Producer Name: _____ Producer Code *(if known)* _____

Contact Person: _____

Street Address: _____

City: _____

Telephone Number ( ) Fax Number: ( )

E-mail Address: _____ Web Address: _____

Requested Commission: _____ Country: _____

Dated as at .....this.....

.

....

Witnessed by Authorized Signature with Company Stamp