



## PROPOSAL FORM

### PERSONAL ACCIDENT / STATED BENEFITS

#### **IMPORTANT - PLEASE READ BEFORE COMPLETING THIS PROPOSAL FORM**

1. The Proposal, together with other information requested by or provided to the Insurers, is required to assist in the evaluation and rating of the risk resulting in the provision of Quotations. Completion of the Proposal does not bind the Proposer or the Insurers to complete the insurance transaction.
2. As the Proposal will form the basis of any insurance contract that may subsequently be issued by the insurers, it is imperative that all Questions be answered in full and to the best of the knowledge and belief of the Proposer – misrepresentation and/or non-disclosure may result in the rejection of claims and/or invalidate the Policy.
3. Should there be insufficient space provided herein, please supply any additional information on separate pages.
4. “Not Applicable” and “N/A” are not suitable responses. **All Questions must be completed in full.**
5. An OFFICIAL Quotation cannot be provided unless all questions have been answered and the **Proposal Form signed and dated.**
6. A full and properly INITIALLED copy of the Proposal Form is required in order for cover to be bound.
7. Please ensure that all responses are clear and legible.
8. **In the event that the Proposer elects not to respond to a Question or specifically request cover in respect of any Section and/or Extension, it will be deemed that cover or a Quotation to include cover is not required.**
9. The completion of this form and the provision of a Quotation and any additional information applicable to the provision of a Quotation, shall not be deemed to be the provision of advice.
10. Should any further/additional information, explanation or advice be required in respect of the product, terms cover etc, this should be sought from an insurance broker.



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11. Any form completed and/or signed by an insurance broker on behalf of the Proposer will be deemed to have been completed by the Proposer.
12. **Please do not tick or cross response boxes or leave them blank, where applicable, respond either "Yes" or "No"**
13. The Proposal Form should not be signed and initialled unless read and understood. Underwriters will consider all signed and initialled Proposal Forms as having being read and understood.



## PROPOSAL FORM

### PERSONAL ACCIDENT / STATED BENEFITS

1. Insured's Name: \_\_\_\_\_  
 (including all Subsidiary Companies) \_\_\_\_\_  
 to be insured \_\_\_\_\_
  
2. Contact Person & Numbers:    Person \_\_\_\_\_  
    Tel No.        (        ) \_\_\_\_\_  
    Fax No.        (        ) \_\_\_\_\_  
    Web Site Address \_\_\_\_\_
  
3. Principal Physical Address: \_\_\_\_\_  
    \_\_\_\_\_  
    \_\_\_\_\_  
    \_\_\_\_\_
  
4. Principal Postal Address: \_\_\_\_\_  
    \_\_\_\_\_  
    \_\_\_\_\_  
    \_\_\_\_\_
  
5. Business Description: \_\_\_\_\_  
    \_\_\_\_\_  
    \_\_\_\_\_
  
6. Please provide the Company:  
    Registration Number        \_\_\_\_\_  
    Vat Number                        \_\_\_\_\_
  
7. Please provide all information on  
    claims paid and outstanding: \_\_\_\_\_  
    \_\_\_\_\_  
    \_\_\_\_\_  
    \_\_\_\_\_  
    \_\_\_\_\_  
    \_\_\_\_\_  
    \_\_\_\_\_
  
8. Has the Entity to be Insured previously been Insured?        Yes ☐    No ☐  
    a)    Has any Proposal for insurance ever been declined?        Yes ☐    No ☐



b) Did any previous Insurer ever require:

i) Increased Premiums or terms?

Yes

☐

No

☐

ii) Special restrictions or conditions?

Yes

☐

No

☐

c) Has any previous Insurer terminated or refused to renew any insurance?

Yes

☐

No

☐

If the answer to any of the above is YES, please give full details:

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9. Please provide any other information that may be relevant to Insurers to assist in understanding the insurance being proposed eg. any unusual or significant hobbies / past time activities.

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10. PERSONAL ACCIDENT BASIS / STATED BENEFITS:

NUMBER OF PERSONS	CATEGORY/ OCCUPATIO N	SUM INSURED							
		DEATH	PERMANENT DISABILITY	TOTAL TEMPORARY DISABLEMENT	TICK CHOICE		MEDICAL EXPENSES	TICK CHOICE	
					52 WEEKS	104 WEEKS		24 HRS	WORK HRS INCL COMMUTE
e.g. 7	e.g. Admin	e.g. 500, 000 OR 2 x Annual	Yes	Yes	104 Weeks		50K	24 hours	



11. IN ADDITION TO THE ABOVE INFORMATION, PLEASE PROVIDE THE FOLLOWING:

CATEGORY / OCCUPATION	ESTIMATED ANNUAL EARNINGS

12. INDICATE THE HIGHEST INDIVIDUAL SALARY:

\_\_\_\_\_

13. INDICATE THE LIMIT PER PERSON REQUIRED:

\_\_\_\_\_

14. INDICATE THE ACCUMULATION LIMIT REQUIRED:

\_\_\_\_\_

## DECLARATION

I/We hereby declare that the above statements and particulars contained in this Proposal are true and complete, that at the present time, other than as stated, I/We have no reason to anticipate any claim under the insurance now being requested.

I/We agree that this Proposal and declaration shall be the basis of the contract between me/us and the Insurers. I/We agree that this Proposal together with any other information supplied by me/us, shall form the basis of any contract of insurance effected thereon, and shall be incorporated therein. I/we undertake to inform the Underwriting Managers of any material alteration to these facts, whether occurring before or after completion of the contract of insurance.

Signed at \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_

Authorised Signatory on behalf of Entity to be Insured \_\_\_\_\_

Capacity \_\_\_\_\_

## INFORMATION

### **PERSONAL ACCIDENT / STATED BENEFITS COVER**

Whilst this information need not be returned to Underwriters for Quotation purposes, it will be deemed to form part of the Underwriting Information provided and is also designed to assist the Proposer in the understanding of the cover to be provided and in the completion of this Proposal Form. Nothing herein will over-ride or amend the terms, exclusions, conditions and limitations of the Insurance Certificate

#### **1. The Insured:**

Only those Companies named in the Proposal will be insured. Please, therefore, ensure that names of all companies to be insured, have been included. It is also imperative that the correct legal entities insured are named in the Certificate, ie **“Limited”**, **“(Pty) Limited”**, **“CC”**, **“trading as”** or **“Sole Trader”**.

#### **2. Cover Required and Annual Earnings:**

For the purposes of calculating Premium, the Estimated Annual Earnings for the forthcoming twelve months must be indicated where Stated Benefits have been requested. The breakdown of employees into the various categories / occupations for both Personal Accident Quotations and Stated Benefits will provide Underwriters with a profile of the risk. However, please note that not all risks may be insured and **Excluded Risks Note 5** below should be referred to.

#### **3. Limits:**

It should be noted that on either basis (Stated Benefits or Annual Earnings), Limits exceeding 5 times Annual Earnings cannot be granted.

#### **4. Optional Extensions**

The following optional Extensions can be requested:-

##### **(a) Temporary Partial Disablement (Accidental)**

Disablement which prevents the Insured Person from attending to a substantial part of the Insured's usual business or occupation.

##### **(b) Temporary Total Disability: (Sickness)**

The onset of any acute somatic, unforeseeable, unpredictable illness (excluding mental illness) which was not a Pre-Existing Condition. Note a four week Excess applies to this Extension.

### **INFORMATION**

(c) **Needlestick Extension (Accidental)**

The cover is for an Insured Person whilst at their usual place of employment and in the course of their duties suffers an accidental injury in which the skin is punctured by a Hypodermic Needle, Scalpel or other Sharp Instrument which is being used in accordance with normal acceptable procedures, or where the Insured Person has been exposed to the bodily fluids of the patient which they are treating, in the facial region

Cover is given for Medical Expenses associated with the HIV antiretroviral treatment packs, and for counselling. This can be sold as a stand alone product.

(d) **Dread Disease Extension**

Cover will apply if during the Period of Insurance, the Insured Person is diagnosed as suffering from a Dread Disease. The Dread Diseases Covered are Heart Attack; Chronic Coronary Heart Disease; Stroke; Cancer; Kidney Failure; Major Organ Transplant; Paraplegia; Blindness; Multiple Sclerosis. The Insured person must survive for a period of at least fourteen successive days after first diagnosis of a Dread Disease for the Policy to respond. Note this Extension is normally limited to 20% of the Death Benefit with a maximum of R150 000.00

#### **5. Standard Exclusions:**

- (a) caused by suicide, or intentional self-injury or exposure to obvious risk of Injury (unless in an attempt to save human life);
- (b) caused by an existing medical condition, physical defect or other infirmity;
- (c) under 15 or over 70 years of age (unless otherwise provided herein);
- (d) whilst travelling by air other than as a passenger and not as a member of the crew nor for the purpose of any trade or technical operation thereon or therein;
- (e) whilst in command of a motor vehicle or craft and the Insured Person's alcohol blood count is higher than the legal limit at the time of the Accident;
- (f) war, terrorism, and riot or civil commotion or public disorder;
- (g) for a venereal disease or Acquired Immune Deficiency Syndrome (AIDS) or Aids Related Complex (ARC) or Human Immuno-Deficiency Virus (HIV) howsoever this syndrome has been acquired or may be named;
- (h) whilst participating in sport as a professional player;
- (i) for any mental and/or nervous disorders, or any like condition arising from or attributable to stress or stress-related situations, other than those caused by Accident as defined in this Insurance.



## **INFORMATION**

### **6. Automatic Extensions On The Policy (Per the Policy Wording)**

DISAPPEARANCE	Will respond if an Insured Person disappears and, after 365 (three hundred and sixty five) days, has not been located
BODY TRANSPORTATION	A limit of up to R5 000 will be paid for returning the body to his/her normal place of residence
RELOCATION COSTS	An amount not exceeding R5000 will be paid, provided that the relocation move is not more than 100 km
EMERGENCY TRANSPORTATION COSTS	If Bodily Injury is sustained at the Insured Person's place of work a sum of up to R15 000 per occurrence will be paid
REHABILITATION COSTS	Insurers will contribute 80% (eighty percent) of such for retraining costs up to a maximum liability of R15000 per Insured Person
MOBILITY COSTS	If the Insured Person suffers Permanent Disability of such a nature that he/she needs, and can operate, a self-powered climbing wheelchair and/or his/her motor vehicle with the controls suitably adjusted, then the Insurers will indemnify the Insured Person for 95% (ninety five percent) of the costs, up to a maximum of R15000 per Insured Person
FUNERAL COSTS (ACCIDENT RISKS ONLY)	Insurers will pay the expenses necessarily incurred in preparing and interring or cremating a deceased Insured Person, including the cost of funerary stonework and urns up to a limit of R5000.
BURNS & DISFIGUREMENT	The overall liability of the Insurers for permanent disfigurement for any one Insured Person shall be limited to 50% (fifty percent) of the amount payable for Permanent Total Disability.