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DUBAI INSURANCE

GROUP PERSONAL ACCIDENT PROPOSAL FORM

1. INFORMATION

a) Broker Name (if any)

b) Name and address of Insured company/Group

c) The Insured Type of Business/ Activities

d) Employees/members to be insured (categories wise)

Occupation of Employees/category	Number of Employees	Limit of Insurance required

e) Total Number of individuals to be insured (please attach a list of insured members with all details: Name, Age, Gender, Nationality, Position and Salary)

f) Total Sum Insured of all members to be insured

g) Period of Cover /insurance required (If not Annual please advise the period)

h) Types of insurance Cover requested

□ Group Personal Accident

□ Workmen's Compensation (for work related injuries only)

□ Group Life and Personal Accident

□ Other, please specify:

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2. Previous Insurance and Claims Experience

a) Would any proposed insured persons have any cause to consider themselves not presently in good health?

☐ Yes	☐ No
if 'YES' please give details:	

b) Do you currently hold or have previously held any personal accident insurance?

☐ Yes	☐ No
if 'YES' please give the following details:	
i) Who is the current insurer?	
ii) Total number of insured persons	
iii) Total Sum Insured	
iv) Paid Annual Premium	

c) Have you or any proposed insured person lodged any claims in the last 3 years?

☐ Yes	☐ No
if 'YES' please give details:	

d) Have you been declined insurance in the past?

☐ Yes	☐ No
if 'YES' please give details:	

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3. BENEFITS AND COVERAGE REQUIRED

Basic Benefits	
a) Accidental Death Benefit	
b) Permanent Total Disability Accident	
c) Permanent Partial Disability Accident	
d) Temporary Total Disability Accident	
e) Accidental Medical Expenses	
Additional Required Benefits (please note by selecting any of the benefits below, your coverage will be broader and it may be considered under other more specialized insurances)	
a) Death Due to any cause / Natural Death	
b) Work related injuries only	
c) Worldwide 24/7 coverage	
d) Permanent Total Disability Sickness	
e) Permanent Partial Disability Sickness	
f) Temporary Total Disability Sickness	
g) Body Repatriation	
h) Critical Illnesses	
i) Health coverage / Medical Insurance	
j) Other please specify	

PLEASE USE THIS SPACE TO RECORD THE ANSWERS TO ANY QUESTIONS FOR WHICH YOU REQUIRE ADDITIONAL SPACE, NOTING THE APPROPRIATE QUESTION NUMBER.

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4. DECLARATION

SIGNING THIS PRPOSAL FORM DOES NOT BIND THE PROPOSER/YOU OR THE INSURER/US/DUBAI INSURANCE CO. TO COMPLETE THIS INSURANCE

The undersigned declares that the statement and particulars in this proposal form are true and that no material facts have been misstated or suppressed after enquiry. The undersigned agree that should any of the information given by us alter between the date of this proposal and the inception date of the insurance to which this proposal relates, the undersigned will give immediate notice thereof. The undersigned agrees that this proposal, together with any other information supplied by us shall form the basis of any contract of insurance affected thereon.

TO BE SIGNED BY THE INSURED FOR WHOM THIS INSURANCE IS INTENDED FOR

SIGNATURE: **DATE:**

NAME: **POSITION:**