

**OLD MUTUAL****PERSONAL ACCIDENT PROPOSAL FORM**

Please give a definite reply to every question - ticks, crosses or dashes are not acceptable

Please use block letters

Name (in full)			
Postal Address			
Business or Occupation			
Telephone	Business	Home	Cellphone
E-mail Address			
First Period of Insurance	From:	To:	

**SCHEDULE OF PERSONS TO BE INSURED**

This insurance can be applied to:

- (i) a fixed scale of compensation for named persons insuring themselves and for employers who wish to insure named employees (Alternative A).
- (ii) compensation based on chosen multiples of average monthly earnings for employers who wish named or unnamed employees (Alternative B).

If desired, cover under Alternative B may be restricted to apply only to bodily injury arising during working hours.

1. Do you require restricted cover?

Please complete the appropriate schedule below

**(I) NAMED PERSONS (age limit 16 – 64 years)**

2 (a) If fixed amounts are required – (Alternative A)

Name	Precise Occupation	Date of Birth

Benefit Required

Death	Permanent Disablement	Temporary Disablement	Medical Expenses	For Office Use Only
				Class:

(b) (i) If a multiple basis is preferred – (Alternative B)

Name	Precise Occupation	Date of Birth	Estimated Annual Earnings	For Office Use Only	
				Rate %	Premium

- (ii) Compensation for death and permanent disablement may be based on 12, 24 or 36 times monthly earnings. State which multiple is required
  - (i) for death
  - (ii) for permanent disablement:
  - (iii) Compensation for temporary disablement may extend for 52 or 104 successive weeks. State which is required:
  - (iv) State sum to be insured for Medical Expenses: \$

## (2) UNNAMED EMPLOYEES (age limit 16 – 64)

## (Alternative B)

## 3. (a) Types of work undertaken (If insufficient space please provide separate full listing)

Estimated Number	Occupation e.g. machine Operator	Estimated Annual Earnings	For Office Use Only	
			Rate %	Premium

(b) Compensation for death and permanent disablement may be based on 12, 24 or 36 times monthly earnings. State which multiple is required for : (i) Death (ii) Permanent Disablement

(c) Compensation for temporary disablement may extend for 52 or 104 successive weeks. State which is required:

(d) State the sum to be insured for medical expenses: \$

## 4. Has any Insurer ever

(a) declined a personal accident proposal from any person or employee to be insured? If so, give full details.	(a)
(b) refused to renew any personal accident insurance?	(b)
(c) imposed any special conditions?	(c)

5. Give particulars of all injuries sustained during the last three years by any person or employee to be insured	

## 6. Is any person or employee to be insured now suffering from ill health or physical defect or infirmity of any description? If so, state in each case.

Name	Age	Occupation	Particulars of ill health or physical disability

7. Is this insurance to be additional to any other personal accident cover in respect of anyone to be insured? If so, give particulars of all other policies


## 8. Do you wish the policy to include:

(a) Bodily injury resulting from riot?

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(a) Disappearance and exposure cover?

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9. The policy will exclude bodily injury sustained while anyone is engaged in rugby or football as an amateur, mountaineering, rock or cliff climbing necessitating the use of ropes or guides, freeform rock or cliff climbing, parachuting, hang gliding, potholing or similar underground activities, speed or duration tests or racing other than racing on foot or yacht racing on coastal waters, steeplechasing, polo, big game hunting, power boating at speeds in excess of 30 knots, water-ski jumping, yachting beyond coastal waters, scuba diving, sports involving snow or ice or synthetic surfaces simulating snow or ice, wrestling, boxing, any professional sport, use of woodworking machinery driven by mechanical power other portable tools applied to the work by hand.

I/We hereby declare that all the above answers and particulars are true and correct and that I/We have not withheld or concealed any circumstances affecting the proposed insurance. I/We agree that this proposal and declaration shall be the basis of the contract between me/us and the Insurers.

Date ..... Year .....

Signature of Proposer .....