

WORK INJURY COMPENSATION INSURANCE PROPOSAL FORM (ANNUAL POLICY)

IMPORTANT NOTICE

- 1) Statement pursuant to Section 25 (5) of the Insurance Act (Cap. 142) (or any subsequent amendments thereof)-You are to disclose in this Proposal Form fully and faithfully all facts which you know or ought to know, otherwise the policy issued hereunder may be void.
- 2) The Work Injury Compensation Act covers all employees regardless of their level of earnings. Whilst insurance for employees who are newly covered under the Act (i.e. those involved in non-manual work and earning above S\$1600 per month) is not compulsory, employers will still be required to pay compensation in the event of a valid claim.
- 3) The Insurer reserves the right to request for more information.

AGENCY:

POLICY NO:

GENERAL INFORMATION

Name of Employer (Proposer):

Business Address:

Website:

ROC No:

Tel No:

Fax No:

Nature of Business:

Period of Insurance: From

To

Places of Employment:

Section 1 - Employees to be insured for Act Benefits and Common Law (please attach list if space is insufficient) All employees within the same category must be insured

Category/Description of Occupations	No. of Employees	Est. Annual Wages, Salary & Living/other allowances (if any)	FOR OFFICE USE ONLY	
			Rate (%)	Premium
❖ Foreign Workers (Work Permit & S-Pass holders)				
❖ All Others				
COMBINED TOTAL				

Section 2 - Employees to be insured for Common Law (Employers' Liability) only (please attach list if space is insufficient)

**All employees within the same category must be insured
Please see Important Notice (2) above before choosing this option**

Category / Description of Occupations	No. of Employees	Est. Annual Wages, Salary & Living/other allowances (if any)	FOR OFFICE USE ONLY	
			Rate (%)	Premium
TOTAL				

Are there any employees based outside Singapore? YES NO If "YES", kindly provide the following details:

COUNTRY BASED IN	NO. OF EMPLOYEES	NATURE OF WORK	ESTIMATED WAGES

Claims Experience for the past 3 years, as at _____(Month/Year)

Insurance Period		No. of Employees	Paid Claims for Period		Outstanding Claims for period	
From	To		Number	Amount (\$\$)	Number	Amount (\$\$)

DECLARATION (Please initial on both page of the form)

I/WE HEREBY DECLARE THAT THE PARTICULARS OF THIS PROPOSAL FORM ARE TRUE, AND I/WE AGREE THAT THIS PROPOSAL SHALL BE THE BASIS OF THE CONTRACT BETWEEN US (EMPLOYER) AND THE INSURER.

I/ WE FURTHER AGREE THAT EMPLOYEES NOT INCLUDED IN CATEGORIES/DESCRIPTION OF OCCUPATIONS (SECTIONS 1 & 2 ABOVE) WILL NOT BE COVERED UNDER THE POLICY.

SIGNATURE OF EMPLOYER & COMPANY STAMP

SIGNATURE OF BROKER/AGENT & COMPANY STAMP

Date:

Date:

NO LIABILITY IS ATTACHED UNTIL THIS PROPOSAL FORM IS ACCEPTED BY THE INSURER

IMPORTANT NOTES

- **UNLESS EXEMPTED, ANY EMPLOYER WHO FAILS TO INSURE HIMSELF IN ACCORDANCE WITH THE WORK INJURY COMPENSATION ACT SHALL BE GUILTY OF AN OFFENCE AND SHALL BE LIABLE ON CONVICTION TO A FINE NOT EXCEEDING \$10,000 OR TO IMPRISONMENT FOR A TERM NOT EXCEEDING ONE YEAR OR TO BOTH.**
- **THE INFORMATION DECLARED IN THIS FORM MAY BE MADE KNOWN TO THE MINISTRY OF MANPOWER AS AND WHEN REQUIRED.**