



شركة الوثبة الوطنية للتأمين ش.م.ع.

ALWATHBA NATIONAL INSURANCE CO. P.S.C.

رأس المال المدفوع والمصرح به (٦٠) مليون درهم خاضعة لاحكام القانون الاتحادي رقم (٩) لسنة ١٩٨١ ومقيدة بسجل شركات التأمين رقم (١٠)

ABU DHABI - TEL.: 6770566, FAX: 6776628, P.O. BOX: 45154
AL AIN - TEL.: 7666641, FAX: 7666692, P.O. BOX: 15883
DUBAI - TEL.: 2228078, FAX: 2270342, P.O. BOX: 6807
SHARJAH - TEL.: 5694490, FAX: 5694491, P.O. BOX: 4131

أبوظبي هاتف: ٦٧٧٠٥٦٦، فاكس: ٦٧٧٦٦٢٨، ص.ب: ٤٥١٥٤
العين هاتف: ٧٦٦٦٦٤١، فاكس: ٧٦٦٦٦٩٢، ص.ب: ١٥٨٨٣
دبي هاتف: ٢٢٢٨٠٧٨، فاكس: ٢٢٧٠٣٤٢، ص.ب: ٦٨٠٧
الشارقة هاتف: ٥٦٩٤٤٩٠، فاكس: ٥٦٩٤٤٩١، ص.ب: ٤١٣١

PERSONAL ACCIDENT INSURANCE PROPOSAL FORM (GROUP)

1. Full Name & Address of Proposer : _____

Tel. No: _____ Fax No: _____

2. Identity or C.R. Number :

3. Trade or Business :

4. State Period of Insurance & commencement date required : _____

5. Please indicate whether the insurance is to be :

a) restricted to occupational accidents only including travel to and from work

b) on a 24 hour basis

6. Please give below details of the persons to be insured

If insurance is required for fixed amounts, complete the following table :

Persons to be insured		Fixed benefits - state amounts to be insured under each heading		
Names (or if defined by category of occupation please state category)	Occupation	Death	Permanent Disablement	Temporary Total Disablement per week *

If insurance is required for multiples or proportions of basic annual wages / salaries complete the following table:

Persons to be insured			State multiples or proportions of basic annual wages / salaries to be insured under each heading		
Categories of Occupation	Number of Persons	Total Annual Basic Wages / Salaries	Death	Permanent Disablement	Temporary, Total Disablement per week *

* The Temporary Total Disablement benefit is for a maximum period of 104 weeks and should not exceed 100% of the basic weekly wage/salary.



AL WATHBA NATIONAL INSURANCE

7. If the benefits selected (overleaf) are related to salary or wages what is the maximum annual salary or wage paid to any person ?

8. State the maximum total benefit required collectively for all persons arising out of any one accident.

9. Do you wish to exclude the first weeks of Temporary Total Disablement for a reduction in contribution (premium) ? If so please state number of weeks.

10. Up to what amount are Medical Expenses to be covered following an accident the cause of which is not excluded under the Policy ?

11. Are any of the persons to be insured over 65 years of age ? If so, give details.

12. To the best of your knowledge are all persons to be insured in good health and free from physical disability ? If not please give details.

13. Do you now hold a personal accident policy ? If so with whom and for what benefits ?

14. Please give details of any accidents causing death or permanent disablement that have occurred during the past 3 years to your employees.

15. Has any Insurer declined a group personal accident proposal for you or declined to continue such an insurance or imposed special terms ? If so give details.

DECLARATION

I/We hereby declare that to the best of my / our knowledge and belief the answers given by me / us in this form are true.

Submitting this form does not bind the Proposer to complete the insurance nor AL WATHBA to accept it, but it is agreed that this form shall be the basis of the contract should a policy be issued.

Signature of Proposer : _____ Date : _____