



INSURANCE COMPANY (BARBADOS) LIMITED

Suite 8, Dome Mall, Warrens, St. Michael BB22026
Telephone: 246-538-2200
Email: infobb@genac.com

EMPLOYER'S LIABILITY PROPOSAL FORM

Policy Number _____ Broker/Agent _____

INSURED'S NAME _____

TRADE OF BUSINESS _____

TAXPAYER REGISTRATION NUMBER (TRN) _____

REGISTERED ADDRESS _____

MAILING ADDRESS _____

TELEPHONE NO.(S) _____ FAX NO. _____ EMAIL ADDRESS _____

DETAILS OF CONTACT PERSON

MR./MRS./MS./
DR./ OTHER _____ FIRST NAME _____ LAST NAME _____

TELEPHONE NO. _____ EMAIL ADDRESS _____

ARE ANY OF YOUR OFFICERS INVOLVED OR ASSOCIATED WITH ANYONE HOLDING ANY PROMINENT PUBLIC POSITION, YES NO
SUCH AS AN OFFICIAL OR EXECUTIVE OF A POLITICAL PARTY, SENIOR POLITICIAN OR SENIOR GOVERNMENT?

IF YES, PLEASE STATE ONE OR THE OTHER

IN RESPECT OF PRINCIPAL OWNERS, DIRECTORS & BENEFICIARIES:

Title	Name	Address

Attach a supplementary sheet, if necessary

WE ALSO REQUEST THAT YOU SUBMIT THE FOLLOWING DOCUMENTS:

- CERTIFICATE OF INCORPORATION (OR SIMILAR DOCUMENT APPROPRIATE FOR BUSINESS)
- MEMORANDUM AND ARTICLE OF ASSOCIATION (OR ARTICLES OF INCORPORATION)
- MOST RECENT ANNUAL RETURNS FILED WITH THE CORPORATE REGISTRY OFFICE OF BARBADOS
- NAME(S) & ADDRESS(ES) OF OWNER(S) WITH SHAREHOLDINGS OF 10% OR GREATER
- COPIES OF ID FROM AT LEAST TWO (2) DIRECTORS. WE ALSO ACCEPT ANY IDENTIFICATION WITH A PHOTOGRAPH, SUCH AS PASSPORT OR DRIVER'S LICENCE

8. Are you at present insured, or have you ever proposed for insurance in respect of your liability to your Employees? YES NO

If so, please state Name of Company: _____

a. Has any such Proposal or Renewal ever been declined or withdrawn? YES NO _____

b. Has an increased rate been required? YES NO _____

Period of Insurance Required

From _____ To _____

Declaration

I/We the undersigned, desire to effect insurance as above stated in terms of the policy to be issued by the Company. I/We agree to keep a proper Wages Record and to render at the end of each Period of Insurance a statement in the form required by the Company of all wages actually paid and to pay premium on any wages paid in excess of the amount estimated above. I/We have hereby declared that all statements and particulars which I/We have read over and checked are true, and I/We have not suppressed, misrepresented, or misstated any material fact and I/We have fairly estimated my/our total wages and salaries expenditure and I/We agree that this declaration shall be the basis of the contract between me/us and the Company.

Date

Signature

Extra Benefits (applicable to cover B only)

Inclusion of Medical Expenses incurred by the Employer.

State what Extra Benefits are to be included. _____

Print Form

Revised: November, 2020