



**WORK INJURY COMPENSATION INSURANCE
PROPOSAL / DECLARATION 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 or more 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.

INTERMEDIARY: ASTRA ASSURANCE AGENCIES LLP

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:

- 1) For New Business, please complete Part A & C
- 2) For Renewal Business, Please complete Part A, B & C

Part A - Annual Policy

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

Estimated Annual Wages * - Refers to wages, salaries and other monetary earnings which must consist of the normal wages, food and housing allowances, overtime payments, bonuses and annual wages supplements but excluding travelling allowances and employers' CPF contributions estimated to be paid during the Period of Insurance.

Category/ Description of Occupations	No. of employees	Estimated Annual wages *
COMBINED TOTAL		



Part C (Declaration)

DECLARATION (Please initial on both pages of the form)

I/WE HEREBY DECLARE THAT THE PARTICULARS ON 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 (PART A & B ABOVE) WILL NOT BE COVERED UNDER THE POLICY.

SIGNATURE OF EMPLOYER & COMPANY STAMP

WITNESS TO EMPLOYER'S SIGNATURE
SIGNATURE OF INTERMEDIARY / EMPLOYEE OF
THE INSURED & COMPANY STAMP

Date:

Name:

Date:

FOR NEW BUSINESS, 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.