

PUBLIC LIABILITY APPLICATION FORM



APPLICANT INFORMATION

Family name: -----			
<i>First</i>	<i>Middle/Father's</i>	<i>Last</i>	
Address: -----			
E-mail address: -----			
Occupation: -----			
Telephone No.:	Home	Mobile	Office
	-----	-----	-----
Requested period of insurance:		From: -----/-----/-----	To: -----/-----/-----

APPLICANT INFORMATION

1. Occupation of premises -----	
2. Brief description of work-----	
3. Are the building plant & machinery maintained & kept in sound & proper conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, please explain-----	
4. Are there any hanging signs, neon signs, outside lamps, and the like at the premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are gases, chemicals or other hazardous materials used or present in your work process?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, please describe the purpose and extent of usage -----	
6. Are there any boilers or pressure vessels used in the premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please give details -----	
7. Does your occupation involve the attendance of a large number of people e.g. hotel, club, church, restaurant and the like?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please state maximum capacity or seating-----	
8. Please state expected annual turnover-----	

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INDEMNITY LIMITATION

1. Bodily injury	\$----- any one person	\$ ----- any one event
2. Material Damage	\$ ----- any one accident;	
3. Bodily injury and Material damage:	\$ ----- any one event.	
4. In the Aggregate, for the policy period:	\$ -----	

INSURANCE HISTORY

1. Is there any other insurance on the same interest in force?	
<input type="checkbox"/> No	<input type="checkbox"/> If yes, please specify name of company & sum insured -----
2. Have you been previously insured?	
<input type="checkbox"/> No	<input type="checkbox"/> If yes, please specify name of insurance company -----
4. Has the insurance now proposed been declined, cancelled, refused renewed or subjected to special terms by any insurance company?	
<input type="checkbox"/> No	<input type="checkbox"/> If yes, please specify name of the insurance company: -----
5. Have you ever suffered any loss for the last 3 years, whether insured or not?	
<input type="checkbox"/> No	<input type="checkbox"/> If yes, please specify when and estimated loss: -----

MODE OF PAYMENT

Premium payment. Please select one of the following options:

	<input type="checkbox"/> Cash
	<input type="checkbox"/> Direct payment (40% down payment and 60% in 3 months from inception date)
	<input type="checkbox"/> Bank Standing Order or "Domiciliation"
	<input type="checkbox"/> Bank Slip payment
	<input type="checkbox"/> Third Party Collection

STATEMENT

We hereby declare that statements made by us in this Questionnaire and Proposal are, to the best of my knowledge and belief, complete and true, and we hereby agree that this Questionnaire and Proposal forms the basis and is part of any policy issued in connection with the above risk.

It is agreed that the insurers are liable in the terms of this Policy only and that the insured will not lodge any other claims of whatever nature.

The insurers undertake to deal with this information in strict confidence.

Name: -----

Date: -----/-----/-----

Signature: _____