



# GRACEKENNEDY GENERAL INSURANCE COMPANY LIMITED

NEW KINGSTON  
Knutsford Boulevard

LIGUANA  
Sovereign Ctr.

DOWNTOWN  
Duke Street

MANDEVILLE  
Midway Mall

MONTEGO BAY  
Fairview Shopping Ctr.

PORTMORE  
Portmore Town Ctr.

Toll Free: 1-888-429-5GKG (429-5454) | Fax: 876-968-1920 | Email: gkinfo@gkco.com | Website: www.gkgeneral.com

## EMPLOYERS' LIABILITY INSURANCE

PLEASE  
USE  
BLOCK  
LETTERS

PROPOSER'S NAME (in full) \_\_\_\_\_ Tel. No. \_\_\_\_\_  
Please state whether Mr., Mrs. or Miss

BUSINESS ADDRESS \_\_\_\_\_

TRADE, BUSINESS OR OCCUPATION \_\_\_\_\_

PARTICULARS OF WORK \_\_\_\_\_

PERIOD OF INSURANCE - FROM \_\_\_\_\_ TO \_\_\_\_\_

### COVER

- (A) In respect of all employees indemnity against your liability at Law other than liability under the Workmen's Compensation Laws. (Please complete Schedule 'A' below. All employees must be included).

### OPTIONAL ADDITIONAL COVER

- (B) In respect of employees within the scope of the Workmen's Compensation Laws indemnity against your liability under such Laws, namely:-  
 Workmen's Compensation Law Cap. 418 and  
 Workmen's Compensation (Amendment) Laws of 1954 and 1960  
 (If this insurance is required please complete Schedule 'B' below. All such employees must be included)

DESCRIPTION OF EMPLOYEES	ESTIMATED NO. OF EMPLOYEES	ESTIMATED ANNUAL WAGES SALARIES & OTHER EMOLUMENTS			FOR OFFICE USE ONLY		
		CASH	LIVING OR OTHER ALLOWANCES (IF ANY)	TOTAL	CLASSIFICATION NUMBER	RATE	PREMIUM
<b>SCHEDULE 'A'</b>							
Please include working Directors  Clerical and Administrative Staff not engaged in manual labour  Commercial Travellers  Woodworking, Machinists and their labourers and assistants  All employees working with or near any other kind of plant or machinery  All other employees (please describe occupations)							
	<b>SCHEDULE 'B'</b>						
	Employees outside the N.I.S.						

TOTAL PREMIUM J\$

If you wish to insure your liability under the Workmen's Compensation Legislation to the workmen of sub-contractors i.e. "contractors" as defined in the legislation, then please state below. This cover only applies to such of the sub-contractors employees that are workmen within the scope of the Workmen's Compensation Legislation

Names of Contractor(s)	Nature of Work Sublet	Total Earnings of Contractors' workmen
1. (a) Does the Schedule 'A' above include all persons in your service? (b) If this insurance is to extend to employees within the scope of the Workmen's Compensation Legislation does Schedule 'B' include all such persons in your service?	(a)  (b)	
2. Do your premises come within the meaning of any law or regulation governing the conduct or maintenance of such premises? IF SO:- (a) Name such laws and regulations (b) Have you carried out all the obligations imposed on you by such laws and/or regulations?	(a)  (b)	
3. (a) Give full particulars of any power driven woodworking machinery (b) Give full particulars of any other power driven machinery	(a)  (b)	
4. Have you any (a) boilers, steam containers or other pressure vessels? (b) lifts, hoists and cranes. IF SO:- (c) When last, and by whom were they examined? (d) are they Insured?	(a) (b) (c) (d)	
5. Are your machinery, plant and ways properly fenced and guarded and otherwise in good order and condition?		
6. State what acids, gases, chemicals or explosives will be used and to what extent.		
7. Do you handle or use radio isotopes or other radio-active substances? If so, give brief particulars.		
8. Do you handle or use any material containing silica or asbestos or any mixture containing either of these materials?		
9. (a) Are you at present Insured or have you ever proposed for Insurance in, respect of your liability to your employees? If. so, state name of Insurers. (b) Has any proposal or renewal ever been declined or withdrawn or policy cancelled? (c) Has any increased rate of premium been asked or special conditions imposed?	(a)  (b)  (c)	

10. State wages expenditure and number of accidents to your employees and of diseases incidental to their occupation, during the past five years.

Year Ending	Approximate Annual Wage Bill	Number of Accidents and Diseases of Occupation	CLAIMS			
			Settled		Outstanding	
			Number	Cost	Number	Estimated Cost

I/We the undersigned desire to effect an Insurance as above-mentioned with and apply to become member(s) of the Association in terms of the Policy to be issued by the Association and the Association's Memorandum and Articles of Association. I/We agree to keep Wages Record and to render at the end of each Period of Insurance a statement in the form required by the Association of all wages actually paid and to pay premium on any wages paid in excess of the amount estimated above. I/We hereby declare that all the above statements and particulars which I/We have read over and checked are true, and I/We have not suppressed or misstated any material fact, that I/We have fairly estimated my/our total wages, salaries and other expenditure and I/We agree that this declaration shall be the basis of the contract between me/us and the Association.

Date \_\_\_\_\_ Proposer's Signature \_\_\_\_\_



## WAGES DECLARATION

INSURED: \_\_\_\_\_

POLICY # \_\_\_\_\_ INSURED BUSINESS: \_\_\_\_\_

PERIOD OF COVER FROM: \_\_\_\_\_ 20\_\_ TO \_\_\_\_\_ 20\_\_

You are reminded that you are bound by the Conditions of your Policy:

- (a) to keep a proper wages record;
- (b) to allow the Company at all times to inspect such record;
- (c) to supply the Company **WITHIN ONE MONTH OF EXPIRY** of the period of insurance with a correct account of all wages, salaries, and other earnings paid during that period

### DECLARATION OF WAGES

This declaration must include the full earnings of all employees covered by the terms and conditions of the above numbered policy. Earnings must include all wages, salaries, bonuses, tips, overnight payments or other special remuneration received by an employee and the actual value of food, fuel and quarters of similar allowances in kind.

Category of Employees	Number of Employees	Payments	Allowances for Food, Fuel or Other	TOTAL

I/We hereby declare that the statement of wages, salaries and other earnings set forth in the Schedule above for the period of insurance as stated is furnished by me/us in accordance with the conditions of my/our Policy; I/We warrant that it is a true statement; that it includes full wages and salaries and that all allowances in kind or money have been included therein.

**Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Insert Company Stamp)