Liberty Videocon General Insurance Company Limited

10th Floor, Tower A, Peninsula Business Park, Ganpatrao Kadam Marg, Lower Parel, Mumbai - 400 013 Phone: +91 22 6700 1313 Fax: +91 22 6700 1606

Email: care@libertyvideocon.com

IRDA registration number: 150 • CIN: U66000MH2010PLC209656



PROPOSAL FORM EMPLOYEES COMPENSATION POLICY

If at any time during the Period of Insurance any Employee of the Insured so declared shall sustain Injury by accident arising out of and in the course of his employment in the Business, Indemnity shall be under Law(s) opted for, subject to the terms, exceptions and conditions contained in the Policy wordings or endorsed hereon, upto the Limit of Indemnity against all sums for which the Insured shall be so liable which is agreed by the Insurer and mentioned on the Policy Schedule.

ne insured	
ser's names in full :	
ser's business address :	
ser's trade or occupation :	
ulars of work to be covered in Detail :	
year did the business commence?	
ocation address(s):	

B. Insurance Requirement

Period of Insurance : From	d	d	m	m	У	У	У	У	То	d	d	m	m	У	У	У	У

Coverage	Scope of coverage	Limit of Indemnity	Coverage Options (Yes / No)
Medical Expenses :	Subject otherwise, to the terms, conditions & Exclusions of the Policy, the amount of liability incurred by the Insured, but not exceeding:	Limit Per Employee for any number of accidents during Period of Insurance Rs	
Occupational Diseases			
Contractors Employees		Limit: As per Employees Compensation Act	

C. Underwriting Information

ALL PERSONS EMPLOYED MUST BE INCLUDED

Wages means the remuneration payable to an Employee by the Insured for the employment in the Business and includes any privilege or benefit which is capable of being estimated in money other than a travelling allowance or the value of any travelling concession or a contribution paid by the employer of a employee towards any pension or provident fund or a sum paid to a employee to cover any special expenses entailed on him by the nature of his employment;

1. OWN EMPLOYEE DETAILS**

Description of Employees	Declared Number of Employees	Total Declared wages during the period of insurance	Place / Places of Employment					
	Employees drawing monthly wages upto Rs 8,000.							
	Employees drawing mont	hly wages above Rs 8,000.						

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2. CONTRACTORS EMPLOYEE DETAILS (if the coverage has been opted for)**

Contractors Name	Registered Address	Declared Number of Employees	Total Declared wages during the period of insurance	Place / Places of Employment					
	Employees drawing monthly wa	ges upto Rs 8,000.							
Employees drawing monthly wages above Rs 8,000.									
** Please attach additional sheets if requi	red.								
•									
3. Any additional information or remarks :									
	All persons in your service?								
(b) <i>F</i>	All your contractors/ subcontractors?								
5. Do you comply with all statutory obligati	ions, manufacturer's recommendations and othe	r safety regulations in cor	nduct of the Business						
6. Do you maintain an accurate record of t	the Employees and Wages in respect of the Busi	noss in compliance with	all etatutory requirements						
o. Do you maintain an accurate record or t	the Employees and wages in respect of the business	ness in compliance with	sir statutory requirements.						
	en safety program?								
Please provide details.									
8. How often is safety inspection conducted	ed on the premises? Please provide details of th	e scope of these inspecti	ons.						
9. Is there provision for emergency medical	al help? Please provide details								
	arriorp. Troduce provide detaile.								
10. What is the availability of labour welfar	re measures? Please provide.								
1. Please provide details of certification for health, safety & environment standards e.g. ISO etc.									
12. Describe the maintenance conditions	of the premises including housekeeping.								
13. Provide details of any other risk features like training, audits etc.									
44 Ass and assulation of the U.S.	:	- de-milede							
4. Are any employees involved in works in connection with explosives, dangerous or toxic chemicals or asbestos?									

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Description of claims

D. Claims / Loss experience

1. What is the claims % (Claim amount as a % of premium paid) over the last 3 years?

2 State t	he total V	Vages n	aid and	narticulars	of accidents	to vour e	employees	during the	nast three	vears *	*
Z.State t	ile iolai v	vayes p	alu allu	particulars	or accidents	to your t	employees	during the	pasi iiiiee j	years.	

Year (Past 3 years from this date)	Wages Paid	No. of claims & Amount of Loss	Description of claims

No. of claims & Amount of Loss

Year [Past 3 years from this date]

3. State the total wages paid and particulars of accidents to your contractor's employees during the past three years. **

Wages Paid

I. Have there been any work place accide	ents in the past which may not have resul	ted in a claim? Please detail out below :				
. After investigation, are you aware of any circumstances which could give rise to a claim under the proposed Policy and which are not mentioned above? If yes, Please provide details:						

DECLARATION

I/We the undersigned this......day of...........desire to effect an insurance in terms of the Policy to be issued by the Company against my/our Statutory, Common Law liability and other covers above mentioned.

I/We hereby declare that all the above statements and particulars, which I/We have read over, checked, are true that I/We have not suppressed misrepresented or mis-stated any material fact, that I/We have fairly declared 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 Liberty Videocon General Insurance Company Ltd.

I/We also agree to inform Company any changes in any respect of any material matter to the grant of a cover in this proposal form/documents/ risk proposed for insurance after the submission of this proposal form.

I/we also agree that the contract of Insurance will be effective only upon Company conveying its acceptance of this proposal, and Company actually receiving or realizing [in case of payment by cheque/DD/PO] of prescribed premium amount, failing which Company's risk is void ab initio.

I/We undertake to exercise all statutory, ordinary and reasonable precautions for safety of all the Employees as if they were uninsured.

Date: d d m m y y y y	Signature of Proposer

^{**} Please attach additional sheets if requried.