Inspac (PNG) Limited

Personal Accident Proposal

PAC 2007

Source		Source Number		Policy Number	

THE PROPOSED INSURED

	Surname (s)	Given Name (s)	
Mr / Mrs/ Mis/ Ms			
Postal Address			
Phone	Office Home	Mobile No.	
Fax	Office Home	Email	
Period of Cover	From ______/______/______to ______/______/______	At 4:00 p.m	
Cover Note Number		Expiry Date	______/______/______

CLAIMS DETAILS

	Please tick	(If 'Yes', full details e.g insurer name, dates)
1. Have you or the person(s) to be insured in the past 5 years made any claim(s) on an insurer for loss or damage?	Yes ☐ No ☐	
2. Have you or the person(s) to be insured in the past 5 years suffered any injury or sickness which would have been covered by the proposed insurance policy?	Yes ☐ No ☐	
3. Have you or the person(s) to be insured in the past 5 years had any insurance declined or cancelled, proposal/application rejected, renewal refused, claim rejected, special conditions or special excess imposed by an insurer?	Yes ☐ No ☐	
4. Have you or the person(s) to be insured in the past 5 years had any previous insurance cover for accident or sickness? If "YES", please give full details of previous cover: If "NO", please specify why there has been no insurance cover up to now?	Yes ☐ No ☐	

INSURANCE COVER

Type of Cover Required	☐ Accident and Sickness OR ☐ Accident only
Benefits Required	☐ Principal sum insured (death by accident and total permanent disability)
	☐ Weekly accident
	☐ Weekly illness
Scope of cover required	☐ 24 hours a day OR ☐ outside working hours

Details of insured person: If group, please provide detailed list	Full name		Date of Birth		Weight (Kg)	
			Male or Female		Height (cm)	

DETAILS OF EMPLOYMENT

Are you self employed?	Yes ☐ No ☐
If 'Yes', have you been self employed for less than 1 year?	Yes ☐ No ☐
What is your occupation	

Are there any circumstances of this person's occupation, habits, sporting or other activities which might make them liable to accident or illness?

(please provide details)

CON'T EMPLOYMENT DETAILS

What are your average weekly earnings?	

(Do not include any unearned income such as rental/investment income). 'Earnings' for a self-employed person mean, the average of gross income for the preceding twelve months derived from personal exertion after deducting all operating expenses of the business or practice.
If group, please provide a detailed list.

What other personal accident cover do you currently hold?

MEDICAL HISTORY OF INSURED PERSON(S)

Has this person (or have these persons) ever being disabled from working for more than 7 days through accident or illness? If 'YES', provide full details	Yes ☐	No ☐

Has this person (or have these persons) ever suffered from any of the following:

(a) Abnormal blood pressure, aneurism, diabetes, gout, rheumatism, rheumatic fever, arthritis, fits, ulcers, cancer, paralysis, varicose veins or hernia? Yes ☐ No ☐

(b) Any disease or disorder of the nervous, mental, digestive, genitor-urinary, reproductive, circulatory or respiratory systems? Yes ☐ No ☐

(c) Any disorder of the back, spine, limbs, heart, sight or hearing? Yes ☐ No ☐

If "YES", to any of the above, provide full details

Has this person/have these persons had any medical treatment or advice during the past 5 years other than for minor complaints such as colds? If "YES", provide full details Yes ☐ No ☐

Has this person/have these persons ever been hospitalized or had any surgical treatment of a serious nature that we should be aware of? If "YES", provide full details Yes ☐ No ☐

Do you anticipate making any flights in charter/private or single engine aircraft? If 'Yes' provide details Yes ☐ No ☐

Has your weight varied by more than 7 kg in the last year? If "YES", provide full details Yes ☐ No ☐

APPLICATION OF COVER

Inspac (PNG) Limited draws your attention to the following **policy conditions**:

1. Any period between the date of an Insured person's total disablement and the commencement of treatment by a duly qualifies medical practitioner is not covered.

2. The maximum period of total disablement during which an insured person can receive Temporary Total Disblem Compensation and Temporary Partial Disablement Compensation is 104 weeks.

3. The policy covers death by accident only. Death caused by illness or disease is excluded.

If you are entitled to receive:

- disability benefits under any other policy insurance;
- weekly compensation under any workers' compensation legislation;
- sick pay from your employer;
- earned income from any other occupation.

Then the amount of compensation payable under this policy will be reduced so that the total of all such payments does not exceed your pre-disability earnings.

WEEKLY BENEFITS

Payments of compensation payable under this policy may be subject to a deferment period. A deferment period means the number of days after medical treatment by a qualified medical practitioner commences before we will pay weekly benefits.

CLAIMS

The policy does not provide cover in relation to events that occurred before the contract was entered into.

DUTY OF DISCLOSURE

Before you enter into a contract of general insurance with us, you have a duty to disclose to us every matter that you know, or could reasonably be expected to know, is relevant to our decision whether to accept risk of insurance and, if so, on what terms. This includes facts which are not subject to questions in this proposal.
You have the same duty to disclose those matters to us before you renew, extend, vary or reinstate a contract of general insurance.

NON-DISCLOSURE

If you fail to comply with your duty of disclosure, we may be entitled to reduce our liability under the contract in respect of a claim or may cancel the contract.
If your non-disclosure is fraudulent, we may also have the option of avoiding the contract from its beginning.

INADEQUATE SPACE TO ANSWER

If there is inadequate space to answer our questions or you need to disclose something to us because of your Duty of Disclosure, please attach a separate piece of paper to these proposal giving full details of additional information.

DECLARATION

I/We the undersigned authorized proposed insured person(s), after enquiry declare as follow;

1. I/We are authorized by each of the other applicants to make this proposal.

2. I/We have read this proposal and the accompanying documents and acknowledge the contents of same to be true and complete.

3. I/We have understand that, up until a contract of insurance is entered into, I/we are under a continuing obligation to immediately inform Inspac (PNG) Limited of any change in the particulars or statements contained in this proposal or in the accompanying documents.

If accepted by Inspac (PNG) Limited the proposal form and declaration, and any other material which I/we have provided to Inspac (PNG) Limited shall be incorporated into and form the basis of the contract of insurance.

Name ____________ Position ____________

Signature ____________ Date ____ / ____ / ____

PREMIUMS & EXCESS DETAILS (OFFICE USE ONLY)			
PREMIUM			
Premium	K		
Stamp Duty	K		
GST	K		
W.COMP. LEVY	K		
TOTAL	K		
EXCESS K			

Inspac (PNG) Limited

P.O. Box 1383, Port Moresby, National Capital District
3rd Floor, Pacific Place Building
Telephone 321 1382, Fax 321 1386
Email : insurance@inspacpng.com.pg