

WORKMEN'S COMPENSATION PROPOSAL FORM

1. INFORMATION		
a) Broker Name (if any)		
b) Name and address of Insured		
c) The Insured Type of Business		
d) Employees to be insured		
Occupation of Employees	Estimated No. of Employees	Estimated Annual Wages
e) Total Number of employees to be insured		
f) Total Estimated Wages of all employees		
g) Period of Cover /insurance required		If not Annual please advise the period
h) Types of insurance Cover requested		
<input type="checkbox"/> As per the UAE Labor Law No. 8 of 1980 and its subsequent amendments		
<input type="checkbox"/> Other		
i) Employer Liability		(if yes please state limit of liability)
<input type="checkbox"/> Yes		<input type="checkbox"/> No



دبي للتأمين
DUBAI INSURANCE

2. EXTENSION COVERAGE/ CLAUSES TO INCLUDE (Please state SI required if any)

<input type="checkbox"/> Waiver of Subrogation	
<input type="checkbox"/> Repatriation Expenses	
<input type="checkbox"/> Heat Stroke/Sun Stroke	
<input type="checkbox"/> Employment Clause	
<input type="checkbox"/> Casual laborers	
<input type="checkbox"/> Employer's Extended Liability Cover any Common Law and/or Sharia Law	
<input type="checkbox"/> Medical Expenses Private Hospitals/Clinics	
<input type="checkbox"/> Hernia	
<input type="checkbox"/> During Transportation to and from Work	
<input type="checkbox"/> Employee to Employee Liability	
<input type="checkbox"/> Employees in Employment Visa to join Insured	
<input type="checkbox"/> 24 Hours non-occupational Personal Accident Cover	
<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:	

3. DOCUMENTS ENCLOSED

SIGNATURE & POSITION

DATE