

## SERVICES

### Application Form

#### 1. APPLICATION FORM

Building Owner  
 Tenant

Applicant Name: \_\_\_\_\_

Business Registration No.: \_\_\_\_\_ Issued Date: \_\_\_\_\_ Issued By: \_\_\_\_\_

Correspondence Address: \_\_\_\_\_  
 \_\_\_\_\_

Insured Location: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_ Website: \_\_\_\_\_

Period of Insurance: From \_\_\_\_\_ To \_\_\_\_\_ (dd/mm/yyyy) - both days inclusive

Nature of Business: \_\_\_\_\_

#### 2. STANDARD COVER

##### SECTION 1: FIRE AND PERILS

##### Building and Content

(Furnitures, Fixtures and Fittings, office and business equipments and all other contents pertaining to Insured/s)

	SUM INSURED (USD)	PREMIUM (USD)
<input type="checkbox"/> Option 1	25,000	25
<input type="checkbox"/> Option 2	50,000	50
<input type="checkbox"/> Option 3	100,000	100
<input type="checkbox"/> Option 4	150,000	150
<input type="checkbox"/> Option 5	200,000	200
<input type="checkbox"/> Option 6	250,000	250
<b>FREE COVER:</b> <b>LOSS OF PROFIT</b>	3% of Adjusted Claim Payable Under Section 1	Free of charge

#### 3. OPTIONAL COVER - LIMIT (USD)

#### PREMIUM (USD)

##### SECTION 2: PUBLIC LIABILITY

<input type="checkbox"/> Option 1	25,000	25
<input type="checkbox"/> Option 2	50,000	50
<input type="checkbox"/> Option 3	100,000	100
<input type="checkbox"/> Option 4	150,000	150
<input type="checkbox"/> Option 5	200,000	200
<input type="checkbox"/> Option 6	250,000	250

##### SECTION 3: GROUP PERSONAL ACCIDENT

SUM INSURED (USD)	NO. OF INSURED PERSON	PREMIUM (USD)/ 1 PERSON	SUB TOTAL (USD)
<input type="checkbox"/> Option 1	2,000	5	.....
<input type="checkbox"/> Option 2	5,000	12.5	.....
<input type="checkbox"/> Option 3	10,000	25	.....
<input type="checkbox"/> Option 4	15,000	37.5	.....
<input type="checkbox"/> Option 5	20,000	50	.....
<input type="checkbox"/> Option 6	25,000	62.5	.....

#### 4. PREMIUM CALCULATION

<b>Section 1: Fire &amp; Perils</b>	USD .....
<b>Section 2: Public Liability</b>	USD .....
<b>Section 3: Group Personal Accident</b>	USD .....
<b>Registration fee USD 1.20 + 10% VAT</b>	USD .....
<b>Total Premium</b>	<b>USD</b> .....

### 5. ADDITIONAL INFORMATION

#### Group Personal Accident

(Please provide the details of employee(s) insured under Section 3)

#### Details of Employees to be Covered

No.	Full Name	ID Number	Year of Birth	Gender
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

### 6. DECLARATION

I/We declare that the above particulars to be true and correct, and agree that they shall be the basis of the contract between Forte Insurance and me/us.

Date ..... Month ..... Year .....

\_\_\_\_\_

(Signature & Stamp)

### 7. IMPORTANT NOTICE

- (i) Statement Pursuant to the Law on Insurance or Any Amendments Thereof: You are to disclose in the proposal, fully and faithfully, all the facts which you know or ought to know, otherwise the policy issued may be void and you may receive nothing from the policy.
- (ii) No insurance is in force until this application is accepted by the Company in accordance to policy terms, conditions and exclusions.
- (iii) If your proposal is accepted, it is a condition precedent to our liability under the Policy that the premium must be paid to and received by us within 30 working days from the inception of the insurance, failing which the Policy shall deem to be automatically terminated and a pro-rata premium will be charged for the period that the Company is on risk.

### 8. AGENT PARTICULARS

Full Name:

Producer Code:

Signature:

Date:

### 9. COMPANY USE ONLY

Received Date:

Payment Method:

Receipt No:

Policy Number:

Name and Signature:

### 10. THE FOLLOWING QUESTIONS MUST BE ANSWERED BY THE APPLICANT:

(Please tick in the appropriate box)	YES	NO
1. Is your insured premises protected with any of the following fire fighting facilities?		
(i) Sprinkler System	<input type="checkbox"/>	<input type="checkbox"/>
(ii) Fire Extinguisher	<input type="checkbox"/>	<input type="checkbox"/>
(iii) Fire Hose Reel	<input type="checkbox"/>	<input type="checkbox"/>
(iv) Fire Alarm System	<input type="checkbox"/>	<input type="checkbox"/>
If all NO, please refer to the Company		
2. Is your insured premises protected with any of the following security measures?		
(i) Solid Door / Gates / Grilles / Roller Shutter / Glass Door	<input type="checkbox"/>	<input type="checkbox"/>
(ii) Burglary Alarm System	<input type="checkbox"/>	<input type="checkbox"/>
(iii) 24-Hour Security Guard	<input type="checkbox"/>	<input type="checkbox"/>
If all NO, please refer to the Company		
3. Is your insured premises constructed of brick/tile/concrete? If NO, please refer to the Company	<input type="checkbox"/>	<input type="checkbox"/>
4. Does any insured proprietor/employee to be insured suffer from any physical defect or infirmity? If YES, please refer to the Company	<input type="checkbox"/>	<input type="checkbox"/>
5. In respect of the risk to be insured, has any previous insurer refused to give cover, renew or imposed any special terms? If YES, please state reason(s):	<input type="checkbox"/>	<input type="checkbox"/>
6. Did you suffer any losses in the past 3 years? If YES, please furnish full details of all claims for the past 5 years:	<input type="checkbox"/>	<input type="checkbox"/>
Date of Loss	Nature of Loss	Loss Amount (USD)