

RETAILS

Application Form

1. APPLICATION FORM	
	<input type="checkbox"/> Building Owner <input type="checkbox"/> 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: _____	
Tax Code: _____	

2. STANDARD COVER	SUINSURED (USD)	PREMIUM (USD)
SECTION 1: FIRE AND PERILS		
Sum Insured / Limit of Liability (USD)		
Building and Content (Furniture, Fixture and Fittings, office and business equipments and all other contents pertaining to Insured's)	<input type="checkbox"/> Option 1 25,000	35
	<input type="checkbox"/> Option 2 50,000	70
	<input type="checkbox"/> Option 3 100,000	140
	<input type="checkbox"/> Option 4 150,000	210
	<input type="checkbox"/> Option 5 200,000	280
	<input type="checkbox"/> Option 6 250,000	350
FREE COVER: LOSS OF PROFIT	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 50,000	25
<input type="checkbox"/> Option 2 100,000	50
<input type="checkbox"/> Option 3 200,000	100
<input type="checkbox"/> Option 4 300,000	150
<input type="checkbox"/> Option 5 400,000	200
<input type="checkbox"/> Option 6 500,000	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	
Section 1: Fire & Perils	USD
Section 2: Public Liability	USD
Section 3: Group Personal Accident	USD
Administration Fee	USD 1.00
Total Premium	USD

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)