

Statewide Insurance Company Ltd.



Head Office: Sure House
Plot 1 Bombo Road | P.O. Box 9393 Kampala
Tel: +256 414 345 996, +256 312 262 119
Email: swico@swico.co.ug, Website: www.swico.co.ug

FIDELITY GUARANTEE PROPOSAL FORM

N.B. All questions must be answered in full. Dashes are not acceptable. Please use BLOCK letters or tick as applicable.

PARTICULARS OF THE PROPOSER

Name of the proposer (in full): _____

Physical Address: _____

Telephone no(s): _____

Email Address: _____

Period of Insurance: From: _____ To: _____

RISK DETAILS

1. Occupation/ Business	
2. Locations of risks to be covered	
3. How long has the business been in operation?	
4. How many employees do you currently engage?	
5. Do you have a system of vetting prospective employees for trust worthiness before employment?	YES <input type="checkbox"/> NO <input type="checkbox"/>

If your answer for question 5 was NO, please give more details:



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DETAILS OF EMPLOYEES

Positions/Names	Designation	Length of service	Amount to be guaranteed (Sum Insured)	
			Per event per person	Per year



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MAXIMUM LIABILITY (AGGREGATE LIMIT) OF THE COMPANY DURING ONE PERIOD OF INSURANCE:
UGX

6. What independent system are in place to check that all transactions done by employees are accounted for?

7. How often will the account books be audited?

8. Do you have an internal audit function? Yes No

If Yes, how often is the internal audit carried out? _____

INSURANCE / LOSS HISTORY

1. Have you ever been insured before? Yes No

If yes, please give name of Insurer

2. Are you currently insured for the type of cover proposed? Yes No

If Yes, please give name of Insurer



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3. Has any office of an Insurance Company, or underwriter ever:

	YES	NO
a) Cancelled your policy?		
b) Declined to insure you?		
c) Refused to renew your policy?		
d) Impose any special terms		
e) Repudiated any claim?		

If the answer to any of the above is YES, please give details:

4. Have you in the last 3 years suffered a loss from fraud or dishonesty of employees?

Yes No

If Yes, give details of:

i. Date of loss: _____

ii. Amount of loss: _____

Name of the Insurance Company with which the Claim was made.

What measures did you take to prevent recurrence?



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DECLARATION

I/We do hereby declare that the above answers and statements are true and that I/we have not withheld any material information regarding this proposal. I/We agree that this declaration and answers given above as well as any proposal or declaration or statement made in writing by me/us or any one acting on my/our behalf shall form the basis of contract between me/us and the company and I/we further agree to accept indemnity subject to the conditions endorsed on the company's policy.

Date of proposal: _____ Signature and stamp of proposer: _____

THE LIABILITY OF COMPANY DOES NOT COMMENCE UNTIL THE PROPOSAL HAS BEEN ACCEPTED AND THE PREMIUM HAS BEEN PAID

AGENT / BROKER / CONTACT PERSON Name: _____

Signature: _____ Date: _____

Comments:



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