PRIME INSURANCE COMPANY LIMITED
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WORKERS' COMPENSATION INSURANCE

PROPOSAL FORM

1. Name of Proposer: .....
2. Address: .....
3. The business: .....
4. Period of Insurance: From: ..... To: .....
5. Schedule of Employees to be covered :

OCCUPATION	EST.NO.	EST. ANNUAL WAGES AND SALARIES AND OTHER EARNINGS
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Date/Stamp ..... Signature .....……