



## PERSONAL ACCIDENT CLAIM FORM

Please note that this form is issued without admission of liability. Please state all relevant information requested as completely and accurately as possible. Please  tick where applicable.

### PARTICULARS OF INSURED (COMPANY / INDIVIDUAL)

Name \_\_\_\_\_ Policy No \_\_\_\_\_

GST Registration No<sup>+</sup> \_\_\_\_\_ Effective Date of Registration<sup>+</sup> \_\_\_\_\_

Business/Home Address\* \_\_\_\_\_ Postal Code \_\_\_\_\_

Tel \_\_\_\_\_ (H) \_\_\_\_\_ (O) \_\_\_\_\_ (Hp)

Email \_\_\_\_\_ Business/Occupation \_\_\_\_\_

### PARTICULARS OF INJURED PERSON / PATIENT

Name of Injured Person/Patient (As in NRIC/Passport) Mr/Mrs/Ms/Mdm/Dr\* \_\_\_\_\_

Occupation \_\_\_\_\_ NRIC/Passport/BC No \_\_\_\_\_

Relationship to Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender  Male  Female  
 (dd/mm/yyyy)

Tel \_\_\_\_\_ (H) \_\_\_\_\_ (O) \_\_\_\_\_ (Hp)

\* If applicable \* Delete if not applicable

### DETAILS OF CLAIM

#### ACCIDENT

Date \_\_\_\_\_ Time \_\_\_\_\_ am/pm\* Place \_\_\_\_\_

State fully what happened \_\_\_\_\_

#### INJURY OR ILLNESS

Nature and Extent of injury or illness sustained \_\_\_\_\_

Has the injured person previously suffered from an injury to the same part or had a similar illness?  Yes  No

If Yes, please give date of symptom first stated / treated \_\_\_\_\_

#### OTHER INSURANCE OR COMPENSATION

Is the Insured or injured person claiming under any other insurance or receiving compensation from any other source?  Yes  No

If Yes, please give details \_\_\_\_\_

### SUPPORTING DOCUMENTS

1. Original medical bills / receipts
2. Medical leave / certificate
3. Medical report
4. Death certificate and Letters of Administration, if applicable
5. Police report, if applicable

### DECLARATION

I/We hereby authorise any hospital, physician, person or organization to disclose all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records. A photocopy of this authorisation shall be considered as effective and valid as the original.

I/We declare that the information given is true and correct to the best of my/our knowledge and belief. I/We understand that any false or fraudulent statements or any attempt to suppress or conceal any material facts shall render the policy void and the Insurer may refuse to pay the claim.

Signature of Insured \_\_\_\_\_ Signature of Injured Person / Patient \_\_\_\_\_

Company's Stamp \_\_\_\_\_ Date \_\_\_\_\_

The Claimant must obtain at his/her own expense the medical report from his/her Medical Attendant.

**TO BE COMPLETED BY ATTENDING PHYSICIAN / SURGEON**

Name of Patient \_\_\_\_\_ NRIC No \_\_\_\_\_

What is the cause of the illness / injury? \_\_\_\_\_

\_\_\_\_\_

Final Diagnosis \_\_\_\_\_

Nature and Extent of Injury \_\_\_\_\_

Is injury likely to cause loss of use of the injured part? \_\_\_\_\_

Is such loss likely to be permanent?  Yes  No

If Yes, to what extent (in percentage)? \_\_\_\_\_

Date when symptom first started \_\_\_\_\_

Details of presented symptoms \_\_\_\_\_

Approximate date of discovery of the illness/injury \_\_\_\_\_

When did the patient first consult you for this condition? \_\_\_\_\_

Nature and Date of Treatment rendered \_\_\_\_\_

\_\_\_\_\_

Doctors previously consulted by the patient for the above condition:

Name	Date	Name of Clinic	Address
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is the patient still under your care for this condition?  Yes  No

\_\_\_\_\_  
Signature of Physician/Surgeon

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name/Designation

\_\_\_\_\_  
Name and Address of Clinic/Hospital