

## DOMESTIC MAID CLAIM FORM

### Important Notice :

- 1 The acceptance of this form is NOT an admission of liability on the part of the Company.
- 2 All documents provided to substantiate your claim must be original documents.
- 3 Please submit a copy of your maid Contract Agreement showing the salary.
- 4 All medical reports must be submitted at the claimant's expense before a claim can be admitted.

Agency \_\_\_\_\_ Policy / Certificate No \_\_\_\_\_

### A. GENERAL SECTION - Please complete this section

#### 1. Policyholder and Domestic Worker Particulars

a. Name of Policyholder

\_\_\_\_\_

b. Address

\_\_\_\_\_

c. Residence / Business Telephone Nos.

(Res) \_\_\_\_\_ (O) \_\_\_\_\_ (HP) \_\_\_\_\_

d. Name of Domestic Worker

\_\_\_\_\_

e. Date of Employment / Passport No. (Please attach copy of Work Permit)

\_\_\_\_\_

f. Name, Address and Contact No. of Employment Agency

Name : \_\_\_\_\_ Contact: \_\_\_\_\_

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

#### 2. Circumstances of Claim

a. Date / Time of accident/illness \_\_\_\_\_

b. Location where injury/illness occurred \_\_\_\_\_

d. Please state exactly what happened (if insufficient space, please attach statement)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

e. Has the insured person sustained an accident/illness of this nature or made any previous claim in respect of insurance previously? Yes  No  If yes, please give details

\_\_\_\_\_

f. Is there any other insurance in force covering this loss? Yes  No

If so, please state Insurance Company and policy number.

\_\_\_\_\_

\_\_\_\_\_

**Documents to be provided as applicable:**

- Medical Report and / or In-patient Discharge Summary
- Original medical bills
- Contract Agreement showing salary for wage compensation claims
- Doctor's Certification for repatriation or termination claims
- Police report if applicable

**B. DETAILS OF THE LOSS**

1. State nature of injuries or illness

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2. State Amount claimed \_\_\_\_\_

3. If accident was caused by a third party please give details of the third party.

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4. Has the sickness been treated previously? Yes  No  If yes, state Name and Address of Physician

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

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

Date of previous treatment: \_\_\_\_\_

5. If injury is due to an accident, are there any more bills to be submitted? \_\_\_\_\_

**C. PAYMENT DETAILS**

a. Please confirm payee name if claim is payable \_\_\_\_\_

Kindly arrange for your doctor to complete the Medical Certificate of Treatment Form if claim is for medical expenses.

I/We hereby declare that the above statements are true to the best of our/my knowledge and belief and I/we undertake to advise the Company promptly of all developments in connection with the claim. I/We further authorise the Company to treat the submission of this form as my/our making a claim under my/our policy.

I hereby authorize any hospital physician, other person who has attended or examined me, to furnish to the Company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, 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.

\_\_\_\_\_  
Policyholder's Signature/Company's Stamp/Date

\_\_\_\_\_  
Domestic Worker's Signature/Date

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name