PERSONAL ACCIDENT CLAIM FORM

Policy No.____

SECTION I – PARTICULARS OF POLICYHOLDER/INSURED AND INSURED PERSON/CLAIMANT

Name of Policyholder/Insured ____ NRIC No. ____________________

Address for Correspondence ____

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Name of Insured Person/Claimant ____ NRIC No. ____________________

Address (Home) ____

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Relationship to Policyholder ____________________________ Date of Birth ____________________ Sex : Male/Female

Telephone No. Office/Home/Mobile ________________________ Email __________________________________

SECTION II – DETAILS OF ACCIDENT

1. Date ______________ Time __________ Place ____
2. How did the Accident happen? What were you doing at the time?
3. What injuries have you sustained?
4. Has the same part been injured previously?
5. Name and address of Doctor who is attending to you. Is he your usual Doctor?
6. Name, address and contact details of any witness of the Accident.
7. Are you claiming under any other insurance? If yes, give particulars.
8. Were you hospitalised? If yes, please state the period of hospitalisation.
9. Were you under the influence of drugs or intoxicants at the time of accident? Yes ☐ No ☐

SECTION III — (A) MEDICAL INFORMATION AUTHORITY AND (B) PERSONAL DATA PROTECTION ACT (MUST BE COMPLETED BY INSURED PERSON/CLAIMANT)

A. I, ________________________________ NRIC No. ____________________ hereby authorise any hospital, surgeon, medical practitioner, clinic, insurance office or other person or organisation who has attended to me for any reason, to disclose to Allied World Assurance Company, Ltd any and all information with respect to any illness or injury and to provide copies of all hospital or medical records/certification, including earlier medical history. A photocopy of this authorisation shall be considered as effective and valid as the original. The information given is true and correct to the best of my knowledge and belief.

B. I/We declare and acknowledge that: (i) all information given in this form is true and correct to the best of my/our knowledge and belief; (ii) I/We have not concealed or suppressed any material fact or made any false statement in relation to the claim; and (iii) I/We acknowledge and consent to Allied World collecting, using, disclosing and processing my/our personal data for the purposes of managing and administering my/our claim including disclosing my/our personal data to third party service providers within or outside Singapore in accordance with the Allied World Singapore Personal Data Protection Policy available at https://www.awac.com/asiapacretail.

________________________________ ________________________________

Signature of Policyholder/Insured / Date and Company's stamp, if applicable

Signature of Insured Person/Claimant / Date (18 years old and above)

NOTE: The issuance of this form is not an admission of liability by the Insurer. The section overleaf must be completed by the Insured Person/Claimant's Attending Physician/Surgeon. The Policyholder/Insured must obtain at his/her own expense the Medical Report from the Insured Person/Claimant's Attending Physician/Surgeon and Allied World Assurance Company, Ltd will reimburse the Policyholder/Insured up to the limit as stated in the Policy. Cheque will be made in favour of the Policyholder/Insured. To submit your claim, please attach all original medical bills and receipts together with this form. If Medisave/Medishield were used, the appropriate amount would be credited into the respective Medisave/Medishield Account.

MEDICAL REPORT

The fee for this report is to be paid by Insured Person/Claimant.

NOTE: This Section is to be completed by the Insured Person/Claimant's Attending Physician/Surgeon whose replies should be as full as possible.

1. What injuries has the Patient sustained?

2. Whether the injuries sustained by the patient were consistent with the circumstances of the accident. If no, please provide more detailed information in relating to the injuries sustained by the patient.

3. When were you first consulted? Was the patient referred to you by a general practitioner? If yes, please indicate his/her name and address.

4. What was your diagnosis?

5. Did injury require

   a) Hospitalisation? ____________________

   b) X-rays? ____________________

   c) Special diagnostic procedures? ____________________

   d) Surgery? ____________________

6. Definition of **TOTAL DISABLEMENT**
   If the injury shall independently of all other causes necessarily, continuously and totally disable the Insured and render him completely unable to pursue his ordinary occupation or to attend to any business affairs whatsoever.

   Definition of **PARTIAL DISABLEMENT**
   If the injury shall independently of all other cause partially disable the Insured and prevent him from attending to a material portion of the daily duties pertaining to his occupation.

   a) How long has the Patient been totally or partially disabled from engaging in or attending to usual business as the result solely of the injuries?

   Totally from ____________ to ____________

   Partially from ____________ to ____________

   b) How much longer do you consider such disablement will continue?

   Totally from ____________ to ____________

   Partially from ____________ to ____________

   c) Is patient fit for work? If Yes, please state date

   Yes ☐ Date: ____________

   No ☐

MEDICAL REPORT

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NOTE: This Section is to be completed by the Insured Person/Claimant's Attending Physician/Surgeon whose replies should be as full as possible.

7. Give details of any circumstances, such as intoxication, physical defects or medical history which may have contributed to the accident.

8. Whether injuries sustained will result in any permanent disablement/incapacity.
   If yes, please specify.

9. Has the Patient any disease or any physical defect and if so of what nature?
   To what extent may recovery be affected thereby?

I hereby certify that I have personally examined and treated the patient for the above injuries and that the facts as given above present my opinion of his/her condition.

Name and qualification of Doctor

Name and Address of Hospital/Clinic

Tel No.

Fax No.

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Signature of Doctor / Date