WORK INJURY COMPENSATION CLAIM FORM

SECTION I – PARTICULARS OF POLICYHOLDER/INSURED

Name ______________________________

Address ______________________________

____

______________________________ Telephone No. ______________

Nature of Business ______________________________ Policy ______________

Is there any other Work Injury Compensation Policy in force providing cover for this loss? Yes ☐ No ☐

If yes, please advise

Name of Insurer ______________________________

Policy details ______________________________

Total number of employees in your employment ______________________________

Are you a GST Registered? Yes ☐ No ☐ If yes, registration no. ______________

SECTION II – THE INJURED PERSON

Name ______________________________ Date of Birth ______________

Address ______________________________

____

Telephone No. Office ______________ Home ______________ Mobile ______________

NRIC/Passport No. ______________ Occupation ______________ Nationality ______________

1. Which category of employees is the injured person ______________________________
2. Number of working days per week ☐ 5 days ☐ 5½ days ☐ 6 days ☐ others ______________ (please specify)
3. Was the injured person engaged in this occupation when the accident occurred? Yes ☐ No ☐
4. Is the injured person in your direct employment? Yes ☐ No ☐
   If no, please advise

   Name of Contractor ______________________________

   Address ______________________________

   ____

   When did the injured person enter your service? ______________________________

   Are you satisfied that the injured person sustained injury arising out of and in the course of employment? Yes ☐ No ☐

   If no, please advise why ______________________________

   Was the injured person free from physical defect or infirmity at the time of accident? Yes ☐ No ☐

   If No, please advise would such physical defect or infirmity contribute towards this accident. Yes ☐ No ☐

   Was the injured person under the influence of intoxicating drink or drugs at the time of accident? Yes ☐ No ☐

5. Was the injured person guilty of any misconduct or disobedience to orders or rules? Yes ☐ No ☐
If yes, please give details

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6. If the accident was due to machinery or gearing
Please advise

i) whether it was fenced or guarded Yes ☐ No ☐

ii) was it being cleared whilst in operation? Yes ☐ No ☐

7. Has the accident been reported to the Ministry of Manpower (MOM)? Yes ☐ No ☐
(Please attach a clear copy of MOM's report to this form)

Has the accident been reported to the Police? Yes ☐ No ☐
(Please attach a clear copy of the police report to this form)

SECTION III – THE ACCIDENT

Date ______________ Time ______________ a.m./p.m. Place ______________

Give full details of the accident

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1. What was the general nature of the contract or work going on? ______________

2. When did you receive notice of accident and from whom? On ______________ From ______________

3. On what date did the injured person actually cease work? ______________

4. If the injured person has received medical, surgical or hospital treatment
Please advise

Name of Clinic/Hospital ______________ [In-patient ☐ Out-patient ☐]

Exact nature of injury ______________

____

Regions affected ______________
(whether left side or right side)

5. What is the probable period of incapacity? ______________ days

6. Has the injured person returned to work? Yes ☐ No ☐
   If yes, when? ______________________________

7. Was the injured person able to do partial work? Yes ☐ No ☐

8. Was there any witness or witnesses to this accident? Yes ☐ No ☐
   If yes, please advise

Name ______________________________

Address ______________________________

____

Telephone No. Office ____________ Home ____________ Mobile ____________

SECTION IV – EARNINGS

"EARNING" include wages, food allowance, housing allowance, overtime, bonus or annual wage supplement but do not include travelling allowance, CPF contributions or pension or money paid to cover any special expenses incurred by nature of employment.

Gross Monthly Earnings for 12 months in the present employment immediately prior to the date of this Accident

YEAR	MONTH	Gross Monthly Earnings (Excluding Bonus)		Annual Wage Supplement/Bonus Paid During Past 12 months	
		$	cts	$	cts
	TOTAL				
	Average	(A1)		(A2)	

Total Average (A1+A2) = $ ______________

SECTION V – FATAL CASES (Additional particulars)

1. Has the deceased any dependants? Yes ☐ No ☐
   If yes, please give particulars below

Name	NRIC No.	Date of Birth	Address	Relationship	Occupation

Telephone No. Office ______________________ Home ______________________ Mobile ______________________

2. Will an inquiry into the death be held? Yes ☐ No ☐
   a) If yes, please advise
      i) date of inquiry ______________________
      ii) place of hearing ______________________
   b) If no, please forward Death Certificate and Post Mortem Report

IMPORTANT NOTICE

1. This form is sent without prejudice to the terms and conditions of the Policy and should not be regarded as a waiver by the Company of any breach of the Policy Conditions which the Insured may have committed.
2. The insured is requested to furnish the particulars above as fully and accurately as possible and this form is to be returned to the Company without delay.
3. All accidents must be reported to the Commissioner for Labour as specified under the Work Injury Compensation Act.

(A) MEDICAL INFORMATION AUTHORITY AND (B) PERSONAL DATA PROTECTION ACT (MUST BE COMPLETED BY INJURED PERSON)

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 copy 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.

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 and Company's stamp, if applicable

Signature of Injured Person / Date

DECLARATION

I/We, the undersigned, do hereby, to the best of my/our knowledge, and belief, warrant the truth of all statements herein and the non-concealment or suppression of any material fact, and I/We further agree and undertake that I/We shall not hereafter make any false statement or conceal or suppress any material fact relating to the accident.

______________________________ ______________________________

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

Date