WORK INJURY COMPENSATION CLAIM (ADDENDUM FORM)

Policy No. _____

SECTION I – PARTICULARS OF POLICYHOLDER/INSURED

Name of Policyholder _____

Address _____

_____

_____

Name of Injured Person _____ NRIC / Passport No._____

Telephone No. Office _____ Home_____ Mobile _____

Number of working days per week ☐ 5 days ☐ 5 ½ day ☐ 6 days ☐ others (please specify) _____

SECTION II – THE ACCIDENT

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

Project Name / Location _____

What was the general nature of the contract or work going on? _____

On what date did the injured person actually cease work? _____

Has the injured person returned to work? If yes, when? _____

Was there any witness or witnesses to this accident? If yes, please advise

Name _____

Address_____

Relationship of witness with Injured Person _____

Telephone No. Office _____ Home_____ Mobile _____

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

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

Signature of Injured Person / Date

SECTION IV – 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

Date

SECTION V – EARNINGS

"EARNINGS" 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) = $ _____

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 and a copy of the i-Report is to be submitted together with this form.