ALLIED WORLD
A FAIRFAX Company

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, please provide your 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 under _____

2. Number of working days per week: ☐ 5 days ☐ 5 ½ day ☐ 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: _____

_____

ALLIED WORLD ASSURANCE COMPANY, LTD (SINGAPORE BRANCH)
incorporated in Bermuda with limited liability

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Singapore 018916

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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 provide the details:

   _____

   _____

   _____

   _____

6. If the accident was due to machinery or gearing, please advise:

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

   ii) Whether it was 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: DD MM YYYY Time: _____ ☐ am ☐ pm

Place: _____

Full details of the accident:

_____

_____

_____

_____

_____

_____

_____

_____

1. What was the general nature of the contract of 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:

   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 probably period of incapacity? _____ Days

6. Has the injured person returned to work? ☐ Yes ☐ No

   If yes, please advise the return date: _____

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

"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) = $ _____

SECTION V – FATAL CASES (Additional Particulars)

1. Has the deceased any dependants? ☐ Yes ☐ No

   If yes, please provide the 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 provide Death Certificate and Post Mortem Report

SECTION VI – IMPORTANT NOTICE

1. The issue and acceptance of this form is without prejudice to the terms and conditions of the policy and is not an admission by Allied World Assurance Company, Ltd (Singapore Branch) (collectively with its affiliates "Allied World") of the claim (whether in whole or in part). It should also not be regarded as a waiver by Allied World of any breach by the policyholder or insured of the policy terms and conditions.
2. To facilitate the processing of the claim, please complete this form as fully and accurately as possible, and return the completed form to Allied World without delay.
3. The information and documents requested in this form are preliminary only. Further information and documents may be required. Allied World may also request for sight of original documents.
4. All accidents must be reported to the Commissioner for Labour as specified under the Work Injury Compensation Act.

SECTION VII – DECLARATION, AUTHORISATION & PERSONAL DATA CONSENT

Declaration

I/We:

(i) confirm that I am/we are the policyholder and/or insured;

(ii) declare, to the best of my/our knowledge and belief, and warrant that:

a. all information in this form is true, correct and accurate in every detail; and

b. I/We have not withheld, concealed or suppressed any material information or made a false statement in relation to the claim;

(iii) further agree and undertake that I/we shall not, subsequent to our submission of this form, make any false statement or conceal or suppress any material fact relating to the claim.

Authorisation

I, _____ NRIC/FIN No. _____

hereby consent to and authorise any person or organisation (including the police, any governmental body, medical practitioner, hospital, clinic, insurer) to disclose to Allied World Assurance Company, Ltd (Singapore Branch) (collectively with its affiliates "Allied World") any and all information, records, reports or certifications as Allied World considers, in its absolute discretion, relevant for its assessment of this claim (including any police records, investigation status and results, hospital or medical records/ certification including earlier medical history respect to any illness or injury). The information given is true and correct to the best of my knowledge and belief. A copy of this authorization shall be as effective and valid as the original.

Personal Data Consent

I/We acknowledge and consent to Allied World collecting, using, disclosing and processing my/our personal data, including disclosing my/our personal data to third party service providers within or outside Singapore, for the purposes set out in and in accordance with the Allied World Singapore Personal Data Protection Statement available at https://alliedworldinsurance.com/singapore/. If I/we have provided or will provide information to Allied World about any other individuals, I/we confirm that I/we are authorised to disclose his or her personal data and also give this consent on both my/our and their behalf.

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