ALLIED WORLD
A FAIRFAX Company

PERSONAL ACCIDENT CLAIM FORM

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

Name of Policyholder/Insured: _____

NRIC No.: _____ Policy No. _____

Address for Correspondence: _____

_____

Name of Insured Person/Claimant: _____

NRIC No.: _____

Address (Home): _____

_____

Relationship to Policyholder: _____ Date of Birth: DD MM YYYY Sex: ☐ Male ☐ Female

Telephone No. (Office): _____ (Home): _____ (Mobile): _____

Email: _____

SECTION II – THE ACCIDENT

1. Date: DD MM YYYY Time: _____ ☐ am ☐ pm

   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?

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

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Singapore 018916

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5. Name and address of the doctor who is attending to you. Is he or she your usual doctor?

6. Were there any witnesses of the accident? If yes, please advise:

Name	Address	Contact details

7. Are you claiming under any other insurance? If yes, please provide details:

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 - PAYMENT DETAILS

☐ **Direct Transfer to Bank**

Please provide a copy of the Insured's bank book/statement for account verification. It must show the bank name, bank account number and full names of all bank account holders.

☐ **PayNow**

Name: _____

NRIC/FIN Number: _____

Important notice: Settlement via PayNow is only available for payees who have registered their NRIC/FIN as a PayNow Proxy with the participating bank. If the PayNow payment mode is selected, please ensure appropriate registration to avoid failure of payment.

SECTION IV – 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. The policyholder and insured must not admit liability, negotiate or settle any third-party claims without the prior written consent of Allied World.
5. Any communication that the policyholder or insured receives regarding the accident should be sent to Allied World immediately (UNANSWERED).

SECTION V – 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 (18 years old and above)

MEDICAL REPORT

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

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

SECTION VI – TO BE ANSWERED IF INJURY DUE TO ACCIDENT

1. What injuries has the patient sustained?

2. Are the injuries sustained by the patient 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 so, please provide the name and address of the referring doctor.

4. What was your diagnosis?

5. Did the 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: DD MM YYYY ☐ Yes ☐ No

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

8. Will the injuries sustained result in any permanent disablement/incapacity?
   If yes, please specify:

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

I hereby certify that the foregoing statement are correct.

Name and qualification of Doctor: _____

Name and Address of Hospital/Clinic: _____

Tel No.: _____ Fax No.: _____

Signature of Doctor/Date: