

Work Injury Compensation

Claim Form



SG011



Important Information

- 1) Insured is requested to state, as fully and accurately as possible, the information asked for below.

- 2) If any detail or information is not readily available, please do not delay the submission of this claim form, but submit further details at a later stage.

- 3) Please send to Chubb Insurance Singapore Limited (Chubb) the following documents:
 - (a) each original medical bill and certificate; and

 - (b) copies of all your correspondences to and from the Ministry of Manpower.

- 4) According to the Work Injury Compensation Act (“Act”) in force as at Oct 2014, every prescribed event that may give rise to a claim for compensation under the Act, should be reported to the Ministry of Manpower.

- 5) In the case of a fatal accident, please inform us of the date and place of Coroner’s Inquiry when it is made known to you and provide us with copies of the death certificate and post mortem report.

- 6) If the injured and/or accident is a subject of claim under Common Law, please forward to Chubb all correspondence that you have received or may receive from the Injured and/or Solicitor(s) of the injured and you must not, in any circumstances, admit liability whatsoever in any manner, be it verbal or in writing.

The issue and acceptance of this form does NOT constitute an admission of liability by Chubb or waiver of its rights.

Section A: Particulars of Insured Company and Injured Worker

Name of Insured Company

Address of Insured Company

Postal Code

Tel No. (Office) _____ Name of Agent / Broker _____

Fax No. (Office) _____ Total No. of Employees _____

Industry of Business _____ Email _____

Policy No. _____

Period of Insurance From DD / MM / YYYY To DD / MM / YYYY

Name of Injured Worker

Address of Injured Worker

Postal Code

NRIC / Passport No. _____ Nationality _____

Date of Birth DD / MM / YYYY Age _____

Tel No. (Mobile) _____ Gender Male Female

Tel No. (Residence) _____ Occupation _____

Date of Employment DD / MM / YYYY No. of days worked per week _____

Direct Employment Yes No Others (please specify) _____

Type of Employment Permanent Contract Others (please specify) _____

Was the Injured Worker free from any physical defect or infirmity at the time of accident? Yes No
(If **No**, please furnish with details)

Would such physical defect or infirmity have contributed towards this accident? Yes No
(If **Yes**, please furnish with details)

Section B: Payment Details

Please provide details for payment of your claim in the event that the claim is deemed payable by Chubb.

I hereby authorise and request Chubb to pay benefit due in respect of this claim as follows:

Cheque Payment

Payee Name (as per bank account name) _____

Electronic Funds Transfer (for payments in SGD and to bank accounts in Singapore)

Payee Name (as per bank account name) _____

Name of Bank _____

Branch Code No. _____ Account No. _____

If no name is provided, settlement will be effected to the payee as provided for under the terms of the policy.

Section C: Details of Accident

Date of the Accident DD / MM / YYYY

Time of the Accident (24-Hour) HH : MM

Country of Accident _____

Place of Accident _____

Describe in detail how the Accident occurred (Please use supplementary sheet if necessary and also state the type of machinery involved, if any)

When did you received news of the Accident _____

When and by whom was the Accident discovered _____

Relationship of person to the Injured Worker _____

Were there witnesses to the incident? Yes No

If **Yes**, please provide details below:

	Witness 1	Witness 2
Name		
Address		
NRIC		
Contact Number		

Describe the nature of the work or contract going on at the material time.

Are you satisfied that the Injured Worker has met with a bonafide accident of employment? Yes No

If **No**, please state reason(s):

Did this accident occur as a result of another person's negligence? Yes No

If **Yes**, please provide details of Negligent party:

Was the Injured Worker guilty of any misconduct / disobedience to orders/rules? Yes No

If **Yes**, please state the misconduct:

Was the Injured Worker under the influence of drink or drugs at the material time? Yes No

If **Yes**, please specify:

Has the Injured Worker met with any previous accident under your employment? Yes No

If **Yes**, please furnish with details:

Has this accident been reported to the Ministry of Manpower? Yes No

(If **Yes**, please attach a copy of I-REPORT)

Please state the date that the Injured Worker returned to work

DD / MM / YYYY

Section D: Nature of Injury

Describe in detail the injuries sustained, indicating the Part(s) of body injured and its type of injury (E.g. Fracture, Cut, Bruise, etc).
(Please use supplementary sheet if necessary)

Has the Injured Worker ever had this or any similar condition or injury? Yes No

If **Yes**, please furnish with details:

Section F: Declaration

Did you remember to enclose the following? (Where applicable)

Document	Yes	NA
Copy of iReport submitted to Ministry of Manpower	<input type="checkbox"/>	<input type="checkbox"/>
Original Medical Bills and Medical Certificates	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Salary Vouchers for the last 12 months (before month of accident)	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Work Permit or Employment Pass (for Foreign employees)	<input type="checkbox"/>	<input type="checkbox"/>
Written notes from Physician on type of injury sustained / Inpatient Discharge Summary or Medical Report	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Death Certificate, Post Mortem Report, Autopsy Report, Police Reports, Letter of Administration (if involved fatalities)	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Contractual Agreement between Insured, Sub-Contractor(s) and/or Main Contractor	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Sub-Contractor's and/or Main Contractor's Work Injury Compensation Insurance Policy	<input type="checkbox"/>	<input type="checkbox"/>

By signing this form, I / We agree that Chubb will use the information supplied here and during the formation and performance of the policy, for policy administration, customer services, claims handling and fraud analysis and prevention, and that Chubb may disclose such information to its service providers, agents, authorities and other parties for these purposes.

I / We hereby authorise any hospital, physician, and any other person or entity who has attended to or examined the injured party, to furnish to Chubb or its authorised representatives, any and all information with respect to any illness or injury or loss, medical history, consultation, prescriptions or treatment, copies of all hospital, medical or other records, investigation status and results, and such personal information as Chubb in its absolute discretion considers relevant for its assessment of this claim. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

I / We do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I / We agree that if I / We have made or in any further declaration or representation shall make any false or fraudulent statements or suppress, conceal or falsely state any fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past, present or future claims shall be forfeited.

Name and Designation of Authorised Person

Signature with Company Stamp

Date

Name of Injured Worker

Signature of Injured Worker

Date

NRIC / Passport No. / Work Permit No. of Injured Worker

Note:

Kindly submit the completed claim form in person, through your Broker, or by mail to Chubb Insurance Singapore Limited at 138 Market Street #11-01 CapitaGreen Singapore 048946. Please ensure that the relevant original copies of supporting documents are submitted as well.

Contact Us

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