Grab

Prolonged Medical Leave Insurance/ Rental Recovery Claim Form

SG020

CHUBB®

Important Notes

This claim form is to facilitate your claim in the event of you or a member of your family is Insured under a Personal Accident policy.

You can help to avoid unnecessary delay in processing your claim by ensuring that:

1. Claim Form is fully completed and signed by the Insured and/or Claimant. Please attach the Original Detailed Pre-Medical/Final Hospitalisation/Post-Medical Report/a copy of the In-Patient Discharge Summary to the Claim Form.

2. Section G is completed by the Claimant's Attending Physician. Please note that you or the Claimant is responsible for any expenses incurred in obtaining medical evidence in support of the claim.

The issue and acceptance of this form and its accompanying documents (if any) does NOT constitute an admission by Chubb Insurance Singapore Limited (Chubb) that any part or the whole of the Claimant's claim is accepted. It also does not constitute a waiver of Chubb's rights in accordance with the terms and conditions of the Policy.

Section A: Particulars of Insured Person

Name of Insured Person (as shown in NRIC/Passport)

_____

Address

_____

_____ Postal Code _____

Policy No(s) _____

NRIC/Passport No. _____ Date of Birth DD / MM / YYYY

Nationality _____ Age _____

Tel No. (Mobile) _____ Gender ☐ Male ☐ Female

Tel No. (Office) _____ Tel No. (Residence) _____

Occupation _____

Email _____

If you are a Driver, please indicate the following:

Driver's Tier _____ Date you become a Grab Driver DD / MM / YYYY

Do you have an active rental agreement with GrabRental or GrabRental's Affiliated Partner on the occurrence of the event?

☐ Yes (A copy of rental agreement is required) ☐ No

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 (Name as per Identification Card and/or Bank Account):

☐ 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. _____

☐ Cheque Payment

Payee Name (as per bank account name) _____

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

The Company shall not be liable for any loss incurred by you as a result of you providing the Company with incorrect bank account details for the payment of your claim.

Section C: Details of Sickness/Accident

Date of Sickness/Accident DD / MM / YYYY Time of Sickness/Accident (24-Hour) H H : M M

Place of Sickness/Accident _____

Description of Sickness/Accident (Please enclose a copy of the Police Report if the accident is due to a road traffic accident)

_____

_____

Section D: Details of Medical Leave due to Accident and Sickness

- Only applicable for Diamond, Sapphire and Ruby Drivers.
- Please remember to affix the company stamp to claim for Temporary Total Disablement.

Medical Certificate From: DD / MM / YYYY To: DD / MM / YYYY Date returned/expected to return to work DD / MM / YYYY

Will there be more medical bills to be submitted at a later date? ☐Yes ☐No

Section E: Details of Hospitalisation due to Accident and Sickness

- Only applicable for Diamond, Sapphire and Ruby Drivers.
- Please attach In-Patient Discharge Summary / Medical Report.

Name of Hospital: _____ Period of Hospitalisation From: DD / MM / YYYY To : DD / MM / YYYY

Section F: Declaration

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

Document	Yes	N/A
Medical Certificate	☐	☐
Doctor's memo on diagnosis (Outpatient)	☐	☐
In-Patient Discharge Summary / Medical Report (Inpatient)	☐	☐
Rental agreement with GrabRental or GrabRental's Affiliated Partner	☐	☐

By signing this form, I/We agree that Chubb will use the information supplied here and during the formation and performance of my 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 me, 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 my 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.

_____
Signature of Claimant

_____
Signature of Insured Person
(if different from Claimant)

_____
Date

Note:

Kindly submit the completed claim form in person or by mail to Chubb Insurance Singapore Limited at 138 Market Street #11-01 CapitaGreen Singapore 048946. You may also email the completed claim form to: A&HClaims.SG@chubb.com

Please ensure that the relevant copies of supporting documents are submitted as well.

Contact Us

Chubb Insurance Singapore Limited
Co Regn. No.: 199702449H
138 Market Street
#11-01 CapitaGreen
Singapore 048946
O +65 6398 8000
F +65 6298 1055
www.chubb.com/sg

Section G: Attending Physician's Statement (To be completed by attending physician)

Note: You are required to complete this section if you are making a claim **without** a Doctor's Memo, Medical Report or In-Patient Discharge Summary.

Name of Patient _____

NRIC/Passport No. _____ Date of Birth DD / MM / YYYY Gender ☐Male ☐Female

Date on which you first saw the Patient DD / MM / YYYY

Is it due to Sickness or Injury? ☐Sickness ☐Injury Date of sickness/injury DD / MM / YYYY

Was the Patient referred to you by another physician? ☐Yes ☐No

If **Yes**, please provide the Name and Address of the referral physician.

Name of Physician

_____

Address _____

_____ Postal Code _____

What symptoms did the Patient complain of?

_____

According to the Patient, how long has he/she been experiencing these symptoms?

_____

In your opinion, how long did the symptoms last?

_____

Has the Patient seen any other physician or receive treatment on account of these symptoms previously? ☐Yes ☐No

If **Yes**, please provide details.

_____

_____

What was your final diagnosis?

_____

_____

Did the injury result in any fracture of bones? ☐Yes ☐No

If **Yes**, please state which part(s) of the body.

_____

_____

Has the Patient previously suffered from an injury on the same part? ☐Yes ☐No

Did the injury or sickness require the following?

1. Hospitalisation ☐Yes ☐No
   (Please state period of hospitalisation: From DD / MM / YYYY to DD / MM / YYYY)
2. X-rays ☐Yes ☐No
3. Special diagnostic procedure ☐Yes ☐No
4. Surgery ☐Yes ☐No
   (Please specify the type of surgery: _____)

Is the Patient still under your care for this condition? ☐Yes ☐No

Bearing in mind the Patient's occupation as stated overleaf, do you feel that the injuries or sickness would have prevented him/her from working? ☐Yes ☐No

Please state the reason why .

_____

_____

How long was the patient totally disabled (unable to work)? _____

Will the Patient continue to be totally disabled (unable to work)? ☐Yes ☐No

How long was the patient partially disabled? _____

Will the Patient be partially disabled? ☐Yes ☐No

Give details of any circumstances, such as the influence of alcohol, drug or any other intoxication substance, physical defects or medical history which may have contributed to the accident or sickness and/or lengthen the period of disability.

_____

_____

I hereby certify that I have personally examined and treated the patient for the above injury / sickness and that the facts as given above present my opinion of his / her condition.

_____ _____

Name of Physician Qualification

Official Address _____

_____ Postal Code _____

Tel /Fax No. _____

_____ _____

Signature with Official Stamp Date

Please click to submit your claim form Submit

Chubb. Insured.™

Published 02/2020.