Personal Accident

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 confined to hospital while being Insured under a Personal Accident policy.

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

1) Sections A to G are 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 Inpatient Discharge Summary to the Claim Form.

2) Section H 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 Policyholder/Insured Person and Claimant

Name of Policyholder/Insured Person (As shown in NRIC/Passport)

_____

Address of Policyholder/Insured Person

_____

_____ Postal Code _____

Policy No(s) _____

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

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 _____

Date of Employment DD / MM / YYYY Name of Intermediary (If any) _____

Name of Employer _____

Name of Claimant (As shown in NRIC/Passport) - if different from Insured Person

_____

Address of Claimant

_____

_____ Postal Code_____

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 _____

Date of Employment DD / MM / YYYY Relationship to Insured _____

Name of Employer _____

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):

☐ 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

Please enclose a copy of Police Report if accident is due to road traffic accident.

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

Country of Accident _____ Place of Accident _____

When and Who discovered the Accident _____

Relationship of person to the Insured _____

Were there witnesses to the incident? ☐Yes ☐No

If **Yes**, please provide details below

	Witness 1	Witness 2
Name		
Address		
NRIC		
Contact Number		

Is this a job-related accident? ☐Yes ☐No

Has this accident been reported to the Ministry of Manpower (MOM)? ☐Yes (please attach a copy of the I-REPORT) ☐No

If **No**, please state reason(s) the accident was not reported to the MOM:

_____

_____

Was the Insured (if a motorcyclist) wearing a helmet at the time of the traffic accident? ☐Yes ☐No

Was the Insured under the influence of alcohol, medication, drugs or any other intoxicating substance at the time of accident? ☐Yes ☐No

If **Yes**, please provide details below (Please use supplementary sheet if necessary)

Name/Type of Alcohol, Medication, Drugs or Intoxicating Substances	Quantity Consumed	Date And Time Consumed

Chronology and Description of the Accident (Please use supplementary sheet if necessary)

_____

_____

_____

_____

_____

_____

Section D: Nature of Injury

Describe in detail the injuries sustained, indicating the part(s) of body injured and its type of injury (Eg. Fracture, Cut, Bruise, etc)

_____

_____

Name and Address of Doctor(s) whom treatment was received from and the Consultation Date(s)

_____

_____

Name and Address of usual physician

_____

_____

Details of Hospitalisation (Please attach In-Patient Discharge Summary and Original Final Hospital Bill)

Name of Hospital _____

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

Details of Temporary Disability from Engaging in or Attending to your Business as a Result of the Injuries

Light Duties From DD / MM / YYYY To DD / MM / YYYY

Medical Leave 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

Are the medical expenses claimable under the Work Injury Compensation Act? ☐ Yes ☐ No

Section E: Retrenchment/Termination Benefit Claim

Name of Employer_____

Date of Employment DD / MM / YYYY Date of Retrenchment/Termination DD / MM / YYYY

Employment Type ☐ Permanent ☐ Contract ☐ Temporary

Reason for Retrenchment/Termination

_____

_____

Section F: Any Other Insurance

Are you claiming from any other insurance company or other sources in respect of injury or illness? If Yes, state:

Name of Insurance Company	Policy No.	Amount of Benefits	Date Insurance Effected

Section G: Declaration

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

Document	Yes	NA
Traffic Police Report (If involved in Road Accident)	☐	☐
Medical Bills (Original copy need to be submitted for Reimbursement claim)	☐	☐
Written notes from Physician on type of injury sustained/Inpatient Discharge Summary or Medical Report	☐	☐
Cover Letter stating personal particulars, contact details, and policy information (If any)	☐	☐
Retrenchment/Termination Letter from Human Resource Department stating employment details (Please include a copy of your CPF Contribution History Statement for the period of unemployment)	☐	☐

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 Policyholder
(Please affix company stamp if applicable)

_____

Date

_____

Signature of Claimant
(If different from Policyholder)

_____

Date

_____

Name & Signature of Insured's Direct Manager (For corporate policies)

_____

Date

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

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

Name of Patient _____

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

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

Is it due to Sickness or Injury? ☐Sickness ☐Accident on DD / MM / YYYY

Was the Patient referred to you by another doctor? If so, please furnish with Name and Address of Referral doctor

Name of Doctor _____

Address _____

What symptoms did the Patient complain of?

_____

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

_____

In your opinion, how long do you feel the symptoms had lasted?

_____

Had the Patient previously seen any other doctor or receive treatment on account of these symptoms? ☐Yes ☐No
If **Yes**, please give details

_____

What was your final diagnosis?

_____

Does the injury result in 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:

- Hospitalisation? ☐Yes ☐No (Please state period of hospitalisation: From DD / MM / YYYY To DD / MM / YYYY)
- X-rays? ☐Yes ☐No
- Special diagnostic procedure? ☐Yes ☐No
- Surgery? ☐Yes ☐No (Please specify 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

And why? _____ _____

How long was or will Patient be continuously totally disabled (Unable to work)?

_____

How long was or will Patient be partially disabled?

_____

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

_____

_____

Tel/Fax _____

_____ _____

Signature with Official Stamp Date

Chubb. Insured.™

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