

WORK INJURY COMPENSATION INSURANCE CLAIM FORM

Agency _____

Policy No _____

Please note:

1. The acceptance of this form is NOT an admission of liability on the part of the Company.
2. All original bills, certificates, Medical Reports, Inpatient Discharge Summary, payslips for past 12 months and other supporting documents should be provided to substantiate your claim.
3. A copy of the Notice of Accident report Form A submitted by the employer to the Commissioner of Labour must be sent to the insurance company with this claim form.
4. If the accident is the subject of a claim under Common Law, you are to forward to the insurance company all letters that you have or may receive from the lawyers for the workman. Liability is not to be admitted in any manner.

SECTION 1 - PARTICULARS OF INSURED

1. Name of Insured: _____ NRIC No.: _____

2. Address: _____ Tel: (O): _____

(H): _____

3. Business: _____ (H/P): _____

4. Has premium been paid? Yes No

5. Have you other policies covering you in respect of this incident? Yes No
If Yes, please furnish details:

SECTION 2 - PARTICULARS OF INJURED WORKER

1. Name of Injured Worker: _____

2. NRIC / Passport No.: _____ Citizenship: _____

3. Sex: _____ Age: _____ Marital Status: _____

4. Home Address: _____

5. Tel: (H): _____ (O): _____ (H/P): _____

6. Is the worker your relative? Yes No If yes, state the relationship:

7. State the occupation in which the worker is employed: _____

8. Was the worker engaged in this occupation when the accident occurred? Yes No
If No, please furnish details:

9. State the date the worker commenced employment with you: _____

10. Did the worker suffer from any physical defect/disability before the accident? Yes No
If Yes, please furnish details:

11. Is the worker your own employee? Yes No

If No, please furnish details of the third party's employer:

Name: _____ Tel No. (O) _____ (H/P) _____

Address: _____

12. Are there other policies covering the worker in respect of this accident? Yes No
If Yes, please furnish details:

SECTION 3 - DETAILS OF ACCIDENT

1. Date: _____ Time: _____

2. Location: _____

3. State the date you received notification of the accident and the name and telephone number of the person who notified you: _____

4. Describe how the accident happened: _____

5. Was the worker under the influence of intoxicating liquor or drugs? Yes No
If Yes, please furnish details.

6. Was the worker injured due to his/her own misconduct or failure to follow instructions? Yes No
If Yes, please furnish details:

7. Was anyone supervising the worker at the time of the accident? Yes No
If Yes, please furnish details:

Name of supervisor: _____ Designation: _____

Address: _____ Tel No: _____

8. Was the accident reported to the Ministry of Manpower? Yes No If yes, please furnish details:

Date accident was reported: _____ (Attach a copy of the notice to this form)

9. What was the general nature of the contract or work going on?

10. If the accident was fatal, state whether an enquiry was conducted: _____

SECTION 4 - PARTICULARS OF WITNESSES

1. Name: _____ Tel : (O) _____ (H/P) _____

Address: _____

2. Name: _____ Tel : (O) _____ (H/P) _____

Address: _____

SECTION 5 - DETAILS OF INJURIES

1. Details of the injuries, including the nature and the extent: _____

2. State the date the worker ceased work: _____

3. Name of hospital / clinic where the worker was treated : _____

Outpatient Inpatient Admitted on _____ Discharged on _____

4. Is the worker still undergoing medical treatment? Yes No

5. Has the worker returned to work? Yes No If yes, please state the date: _____

6. In Death cases, please furnish:

a) a copy of the Death Certificate, Post Mortem report and police report (if any).

b) a list of the deceased's dependants, stating names, addresses, ages, relationships and occupations.

