Work Injury Compensation

Claim Form

SG011

CHUBB

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) H H : M M

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:

_____

_____

_____

Please state all medical condition(s) or previous injury sustained by the worker and also indicate which are the injuries that arose out of Work Injury accidents. (Please use supplementary sheet if necessary)

_____

_____

_____

_____

_____

_____

Date of first treatment sought DD / MM / YYYY

Name of Hospital / Clinic _____

Address of Hospital / Clinic _____

Tel / Fax _____

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

Period of Medical Leave From DD / MM / YYYY To DD / MM / YYYY

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

Section E: Detailed Earnings of The Injured Worker

Please provide detailed gross monthly earnings of the Injured Worker for 12 months (**before month of accident**):

Month / Year	Gross Monthly Earnings (Exclude Bonuses, Transport Allowance, CPF Employer's Portion)	Annual Wage Supplement / Bonus Paid During Last 12 Months
Total Annual Earnings		
Average Monthly Earnings		

Section F: Declaration

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

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

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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