SOMPO

Sompo Insurance Singapore Pte. Ltd.
50 Raffles Place, #05-01/06 Singapore Land Tower, Singapore 048623
Tel: 6461 6555 | Fax: 6221 3302 | Website: www.sompo.com.sg
Co. Reg. No.: 198905490E | GST Reg. No.: M200903196

Personal Accident Claim Form

Important Notice:

1 The acceptance of this form is NOT an admission of liability on the part of the Company.
2 All original final bills, certificates, supporting documents should be provided to substantiate your claim.
3 All medical reports must be submitted at the claimant's expense before a claim can be admitted.
4 Please answer in full all applicable questions as incomplete answers may delay claims settlement.

Agency : ____ **Policy No:** ___________________________________

Claim documents submitted by ☐ Self ☐ Intermediary

Have you notified us of this claim earlier? ☐ No ☐ Yes by email / fax / telephone call to________________________

If yes, state any reference number assigned to you earlier: Claim no / Temporary ref no___________________________

Useful notes:

a) Medical and TCM bills must indicate a breakdown of the expenses incurred (consultation and medication prescribed). Do not submit receipts as these will not show enough information for the claim to be assessed.

b) The doctor's diagnosis must be clearly stated especially for claims made under extended benefits, for example, food poisoning, insect bites.

1. PARTICULARS OF POLICYHOLDER

a. Name of Insured ____

b. Address ____

c. Residence / Business Telephone Nos.

(Res) __________________________(O) ___________________________(HP) ____________________________

d. Email _______________________________________ **e**. Business / Occupation _________________________________

2. PARTICULARS OF THE INJURED PERSON (CLAIMANT)

a. Name of Claimant ☐ As above ____

Age _____ Date of birth ____________ NRIC / Passport No. of Claimant: _________________________

b. If claimant is not the policyholder, state relationship to policyholder ______________________________________

c. If dependent is employed, state occupation :____

d. If Employee, state date of employment and occupation

Date: __________________________________ Occupation: ____

3. PARTICULARS OF ACCIDENT

Please attach as applicable :

1) Medical Report 2) Medical Bills and Certificates 3) Police Report
4) Death Certificate / Letter of Administration

a. Date /time of accident __________________________________ **b.** Location ___________________________________

c. State name and address of any person(s) who witnessed the accident

Name : ____Contact: _________________________

Address : ____

d. Are you entitled to receive compensation from any other source for this accident? ☐ Yes ☐ No

If yes, state: From what source : ______________________________

To what extent : ______________________________

e. Have you ever made a claim for compensation in respect of accidental injury from any Insurance Company?

☐ Yes ☐ No If yes, give particulars.

____

f. State how accident occurred and what claimant was doing at the time. **Attach Police Report if applicable**.

____

____

____

g. Please state as precisely as you can the injuries sustained, indicating the part of the body injured and the type of injury (eg, fracture, cut, bruise etc.)

____

____

h. Date returned / expected to return to work ______________________________

i. If still receiving treatment, please state nature of treatment and next scheduled medical appointment

____

____

______________________________ Date of next Appointment: ______________

j. Amount claimed ______________________________

k. Will there be any more bills to be submitted? ☐ Yes ☐ No ______________________________

4. PAYMENT DETAILS (if claim falls within terms and conditions of the policy)

Please confirm payee name if claim is payable ______________________________

Note: If payee is different from claimant or is not listed in the policy please provide a Letter of Authorisation.

We may request for your doctor to complete the Medical Certificate of Treatment (Personal Accident) Form if we require further clarification of your claim.

Declaration and Authorisation – To be signed by claimant

We/I hereby declare that the above statements are true, accurate and complete and I understand that if I have in this or in any further declaration in respect of this claim, made any false or fraudulent statement or suppress conceal or falsely state any material fact whatsoever my claim may be refused. We/I undertake to advise the Company promptly of all developments in connection with the claim and to render every assistance in dealing with the matter. I/We further authorise the Company to treat the submission of this form as my/our making a claim under my/our policy.

I acknowledge and agree (in case of corporate policy, I represent that I have obtained the consent of the individuals in relation to this policy) that Sompo may collect, use, disclose and/or process my personal data (in case of corporate policy, personal data of individuals in relation to this policy) in accordance with the Personal Data Protection Act 2012 for the purposes and uses described in Sompo's Privacy Policy (including the provision of protection, services related to this insurance policy, screening activities in accordance with legal/regulatory obligations/risk management procedures). This may include disclosure to Sompo's business partners, intermediaries, third party service providers and industry associations. Sompo's Privacy Policy can be found at www.sompo.com.sg

______________________________	______________________________
Signature of Claimant	Date
______________________________	______________________________
Name	NRIC Number