

Work Injury Compensation 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 including **Medical Report, Inpatient Discharge Summary, Referral for Continuation of Treatment Form, payslips for the past twelve (12) months** should be provided to substantiate your claim.
- 3 A copy of the **i-Report** submitted by the employer to the Ministry of Manpower (MOM) must be sent to the Insurance Company together with this Claim form.
- 4 As per Work Injury Compensation Act, every accident involving your employee(s) must be reported to the Ministry of Manpower within **ten (10) days** of the accident otherwise you may be punished with a fine. You must also submit your claim form to the Insurer as soon as possible so as not to prejudice your claim.
- 5 If the accident is the subject of a claim under Common Law, you are to forward to the Company all letters that you have or may receive from the lawyers for the workman and you must not admit liability in any manner.
- 6 All medical reports must be submitted at the claimant's expense before a claim can be admitted.
- 7 Please answer in full all applicable questions as incomplete answers may delay claims settlement.

Agency _____ Policy / Certificate No _____

1. INSURED DETAILS

- a. Name of Insured _____
- b. Address _____
- c. Business _____
- d. Name of Contact Person / Contact No.
 Contact Person: _____ Contact No: _____ Email _____
- e. Company Details
 Total No. of Employees: _____ Total Earnings for the twelve (12) month period prior to the accident: _____
- f. Has the accident been reported to MOM? Yes No
 If yes, please provide us with a copy of the completed MOM claim form

2. INJURED PERSON DETAILS

- a. Name _____
- b. Residential Address _____
- c. Contact No.
 (Res) _____ (HP) _____ Email _____
- d. Sex / Age: Female Male / Age: _____
- e. Marital Status: Single Married Others: _____ State number of dependants if any _____
- f. Nationality / Identity Card or Passport Number (Please provide copy of work permit) _____
- g. Date of Employment _____
- h. State injured person's occupation : _____
- i. Average Monthly or Daily Wage : \$ _____ per month / day
- j. On what work was the injured person engaged in at the time of the accident?

3. IS THE INJURED PERSON IN YOUR DIRECT EMPLOY Yes No If 'No', please complete this section

Name of direct employer _____
 Address of direct employer _____
 Contact No. of direct employer: _____ Annual WC Insurer of direct employer: _____

4. TREATMENT DETAILS / STATUS OF INJURED PERSON

a. Name of hospital / clinic taken to

b. Admission Details

Out-patient In-patient Day Surgery Admit on _____ Discharged on _____ No. of Days _____

c. Has injured person returned to work? Yes No

If yes, state date return to work, if no, state when medical leave ends

d. Is the injured person still in your employ? Yes No

e. Is the injured person able to do partial work? Yes No

f. What is the probable period of disablement (approximate)?

g. Was the injured person employed on a 5-day week basis at the time of accident? Yes No

5. DETAILS OF THE ACCIDENT

a. Date and time of accident

Date: _____ Time: _____

b. Location where accident occurred

c. On what date did you receive notice of accident and from whom?

d. Was anyone superintending the work the injured person was engaged in? Yes No

If yes, state name, occupation and contact number

Name: _____ Occupation: _____ Contact No: _____

e. Did the accident involve machinery or gearing? Yes No

If yes, was it fenced or guarded Yes No

was it being cleaned whilst in motion Yes No

f. Describe exactly how the accident happened? If insufficient space please use Section E on last page.

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

h. State nature of injury in detail

7. MONTHLY EARNINGS DETAIL

- a. The object of this Section is to ascertain the exact Monthly Earnings of the injured person. It is essential that it should be carefully and correctly filled in. If the injured person has been absent from work at any time during the period of employment, please state the period and the cause.
- b. If the injured person has been employed for more than a period of ONE (1) year, the Employer MUST SHOW the whole of the previous years wages paid to the employee including payment for overtime, bonus and other allowances.
- c. If the injured person has been employed for less than one (1) year, please complete statement of wages IN THE PRESENT EMPLOYMENT immediately prior to the date of the accident, stating the date on which he was engaged.

	MONTH	No. of Working Days	Gross Monthly Earnings [Excluding Bonus]		Annual Wage Supplement/Bonus Paid during Past Twelve (12) Months	
			\$	cts	\$	cts
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
TOTAL						
MONTHLY AVERAGE						

Declaration

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 Insured (with Company's Stamp)

Date

Name of Authorised Signatory

Designation