

Liability Claim Form

Important Notice:

- 1 The acceptance of this form is NOT an admission of liability on the part of the Company.
- 2 The insured must state all information requested as fully and accurately as possible.

Agency _____ Policy / Certificate No _____

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

Please state any reference number assigned to you earlier: Claim no / Temporary ref no _____

1. INSURED'S PARTICULARS

- a. Name of Insured _____
- b. Address _____
- c. Contact Nos. (Res) _____ (Off) _____ (HP) _____
- d. Fax _____ Email address _____
- e. Contact Person / Contact information _____
- f. Are you a GST registered Company? Yes No If yes, GST registration No _____
- g. Do you have other policies covering you in respect of this incident? Yes No If yes, please give details.

2. PARTICULARS OF ACCIDENT

- a. Date: _____ Time: _____ b. Location _____
- c. When did you receive notice of accident? By whom? Please give details of the person reporting.
 Date: _____ Person Reporting : _____
 Contact No: _____ Designation : _____
- d. Has a claim been made upon you in respect of this accident? If so, for what amount?
 Yes No Amount claimed: _____
- e. State clearly how the accident occurred.
Attach Police Report if applicable. If insufficient space, please attach separate page

- f. Did the accident arise from the negligence of your employee(s)? Yes No
 If yes, give details including contact numbers of the employee(s) and why you consider the employee negligent:

3. PARTICULARS OF WITNESSES

It is very important that the details of all witnesses be furnished immediately.

Name : _____ Contact: _____

Address : _____

Relationship of Witness: _____

PLEASE COMPLETE ONLY THOSE SECTIONS WHICH ARE APPLICABLE TO YOUR CLAIM.

4. PROPERTY DAMAGE

Description and Extent of the Property Damaged	Approximate Value of Property Damaged	Estimated Cost of Repairs to the Property Damaged

5. INJURY

Name/Address/Contact No./Occupation of Person Injured	Nature and Extent of Injuries	Was the Person Injured taken to the hospital? If yes, which hospital?

a. Was the accident contributed to or caused by negligence on the part of the injured person? Yes No
If yes, in what way was he negligent?

b. Is the injured person(s) in your direct employ? Yes No

c. Is the injured person's employer your sub-contractor? Yes No If yes, provide copy of contract.

d. Is the injured person(s) in the employ of a person to whom you are a sub-contractor? Yes No
If yes, please provide copy of contract.

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 Claimant
(Affix Company stamp if applicable)

Date