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Co. Reg. No.: 198905490E | GST Reg. No.: M200903196

Work Injury Compensation Claim Form

(This claim form is to be used only if an iReport has already been lodged with the Ministry of Manpower)

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 Treament 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 2019, 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. Name of Contact Person / Contact No.

Contact Person: _____ Contact No: _____

c. 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. Address in Singapore _____

c. Contact No. _____ (HP) _____ (Res) _____

Email address _____

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 _____

Out-patient☐ In-patient☐ Day Surgery☐ Admit on _____ Discharged on _____No. of Days ____

b. Has injured person returned to work? ☐ Yes ☐ No

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

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

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

5. DETAILS OF THE ACCIDENT

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

_____

b. 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: _____

c. State nature of injury in detail

_____

_____

_____

d. State the names, occupation and contact numbers of any persons who witnessed the accident

Name	Occupation	Contact Numbers

6. 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 injured person 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