Sompo Insurance Singapore Pte. Ltd.
UEN: 198905490E
GST Reg No: M200903196

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 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 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 fined. 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 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 I-Report

2. INJURED PERSON DETAILS

a. Name: _____

b. Address in Singapore: _____

c. Contact No.:(HP) _____ Email: _____

d. Gender / Age: ☐ Female ☐ Male / Age: _____

e. Marital Status: ☐ Single ☐ Married ☐ Others: _____ Number of dependents (if any) ____

f. Nationality & NRIC No./FIN No. (Please provide copy of work permit): _____

g. Date of Employment: _____

h. Injured Person's occupation: _____

i. Average Monthly or Daily Wage: $_____per month / day

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

a. Name of Direct Employer: _____

b. Address of Direct Employer: _____

c. Contact No. of Direct Employer: _____

d. Annual WC Insurer of Direct employer: _____

e. Nature of contract with the Direct Employer: _____

4. TREATMENT DETAILS / STATUS OF INJURED PERSON

a. Name of hospital / clinic where the Injured Person was treated:

_____

b. Admission Details:

☐ Out-patient ☐ In-patient ☐ Day Surgery

Admission date: _____ Discharged date: _____ No. of Days _____

c. Has the Injured Person returned to work?

☐ Yes, please state date return to work: _____

☐ No, please state when the 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. Injured Person's no. of work day per week at the time of accident?

☐ 5 days ☐ 5.5 days ☐ 6 days ☐ Others, please specify _____

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 supervising the injured person? ☐ Yes ☐ No

If yes, state name, occupation and contact number

Name: _____ Occupation: _____ Contact No: _____

e. Describe exactly how the accident happened? If insufficient space please use Section 6 on page 3.

_____

_____

_____

_____

f. State nature of injury in detail:

_____

_____

_____

_____

g. If it was a fatal accident, please state whether a Coroner's Inquiry was conducted and the details.

_____

_____

h. Was the injured person under the influence of alcohol or drugs at the time of the accident? ☐ Yes ☐ No

i. Was he guilty of any misconduct or disobedience to orders or rules? ☐ Yes ☐ No

If so, please give full particulars.

_____

_____

_____

_____

j. In your view, who was the negligent party in this accident:

_____

k. Was a third party involved? ☐ Yes ☐ No

If yes, please provide name, company and contact no.

Name: _____ Contact No: _____

Company: _____

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

Name	Occupation	Contact Numbers

6. ADDITIONAL SPACE FOR DETAILS OF CLAIMS

_____

_____

_____

_____

_____

_____

_____

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_____

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_____

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