Tenet Sompo Insurance Pte. Ltd.

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WORK INJURY COMPENSATION CLAIM FORM

Important Notice :

1 This form is issued without admission of liability.

2 All **original** bills, certificates, supporting documents including **Medical Report, Inpatient Discharge Summary, Referral for Continuation of Treatment Form, payslips for 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 injured person and you must not admit liability in any manner.

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.

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

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h. State nature of injury in detail

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i. If the accident is a fatal one, state whether an enquiry was conducted

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

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

If so, please give full particulars.

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l. State through whose neglect the accident occurred, if any.

____

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

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

Name: ______________________________ Contact No: ______________

Company: ____

n. 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 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						

7. ADDITIONAL SPACE FOR DETAILS OF CLAIMS

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Declaration

We/I hereby declare that the above statements are true, accurate and complete true, accurate and complete and we/I undertake to advise the Company promptly of all developments in connection with the claim. We/I further authorise the Company to treat the submission of this form as our/my 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 Tenet Sompo Insurance 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 Tenet Sompo Insurance'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 Tenet Sompo Insurance's business partners, intermediaries, third party service providers and industry associations. Tenet Sompo Insurance's Privacy Policy can be found at www.tenetsompo.com.sg

_______________________________ _______________________________

Signature of Insured (with Company's Stamp) Date

_______________________________ _______________________________

Name of Authorised Signatory Designation