WORK INJURY COMPENSATION INSURANCE CLAIM FORM

Agency: ______________________________ Contact No.: ________________ Email address: ____________________

N.B. 1. Full particulars of the accident are to be furnished by the employer described in this form.
2. The giving of the undermentioned information does not imply that the injured person is making, or will make, a claim.
3. This form is sent without prejudice to the terms of the policy described in this form.
4. This form is to be completed and forwarded without delay. Any details of information not readily available may be supplied as soon as obtainable.
5. All written communications received by the employer concerning the accident to its employee should be forwarded at once to Great Eastern General Insurance Limited (“Company”).

THE EMPLOYER

Name of Policyholder: _____________________________ Policy No: ________________________________
Business:____________________________________ Contact No.: ___________________ Email: ______________________
Address: _________________________________________________________________________________

THE INJURED PERSON

Name: ________________________________________ Nationality: ______________________ Date of Birth: ___________ Gender: ________
Local Address: _____________________________________________________________________________
When did the injured person enter your service? _________________________________________________

Work in which the injured person is usually employed: ____________________________________________

Was the injured person engaged in the above work when the accident occurred? _____________________

Is the injured person, your direct employee, contractor’s employee or a sub-contractor? ______________

Name of hospital taken to: _____________________________ In or out-patient: ____________________________

State whether still in hospital, or date discharged: ________________________________________________

Has the injured person been medically examined? If so, please send report. If not, was free medical examination offered?
____________________________________________________________________________________________

State whether returned to work, and if so, when? _________________________________________________

The injured worker works a five or five and a half day week or alternate Saturday: _____________________

Are you satisfied the injured person has met with a bonafide accident arising out of his/her employment? __

Is the injured person able to do partial work? _____________________________________________________

What is the probable period of disablement (approximate)? _________________________________________

THE ACCIDENT

Date: ___________________________ Time: ___________________________ Place: ___________________________
On what date did you receive notice of accident and from whom? If in writing, please attach to this form: _________________________________
On what date did the injured person actually cease work? _________________________________________

Briefly describe what was the cause of the accident and how it happened.
____________________________________________________________________________________________
If from machinery or gearing
(a) Was it fenced or guarded.
(b) Was it being cleaned whilst in motion?

Briefly describe the nature of injury sustained.
____________________________________________________________________________________________

What was the general nature of the contract or work going on?
Where amputation is involved, please state precisely at which phalanx/part was amputated and state left or right side

Was the injured person under the influence of drink or drugs at the time of the accident?

Was he/she guilty of any misconduct or disobedience to orders or rules? If so, please give full particulars.

State through whose neglect the accident occurred, if any:

State the name of any persons who witnessed the accident:

Has the accident been reported to the Commissioner for Labour and Police? State when and where

Additional particulars for FATAL CASES only

Has the deceased any dependants? State names, addresses and relationship

Will an enquiry into the death be held? If so, please supply a copy of the notes as soon as possible. 

If no enquiry will be held, a Medical or the Post Mortem Certificate is required.

Statement of wages of the Injured Person earned IN THE PRESENT EMPLOYMENT for twelve months immediately prior to the date of this Accident, or wages earned during such shorter period as he/she may have been in the Employer's service, stating the date on which he/she was engaged.

Note:- The object of this form is to ascertain the exact Monthly earnings of the injured person and should be correctly filled in. If the injured person has been absent from work at any time during the period of his/her employment, please state the period and the cause.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MONTH</th>
<th>WAGE</th>
<th>Bonus, Value of Free Quarters &amp; any other Allowances</th>
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</thead>
<tbody>
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<td></td>
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TOTAL

Total including all allowances

DECLARATION AND CONSENT

We hereby declare that the particulars stated above are true and correct in every detail and we agree that if we have made or in any further declaration in respect of the same claim shall make any false or fraudulent statements or suppress conceal or falsely state any material fact whatsoever the relevant insurance policies shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

In addition to the declaration provided above, we hereby represent that the relevant employees have agreed and consented to the Company, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents collecting, using, disclosing and sharing amongst themselves their personal data, and disclosing such personal data to the Companies' authorised service providers and relevant third parties for purposes reasonably required by the Companies to evaluate, admit, process and/or administer our claims.

These purposes are set out in Great Eastern's Privacy Statement, which is accessible at http://www.greateasternlife.com/sg/en/pncpolicies.htm and which I/we confirm the relevant employees have read and understood.

Signature of Employer: ____________________________ Company’s Stamp: __________________

Name:__________________________________________ Designation:___________________________

Date: __________________________________________