Tokio Marine Insurance Singapore Ltd.
Company Reg. No. : 192300014M
20 McCallum Street
#09-01 Tokio Marine Centre
Singapore 069046
Tel : (65) 6221 6111 Fax : (65) 6225 9887
Email : tmis@tokiomarine.com.sg
Website : www.tokiomarine.com.sg

Personal Accident Claim Form

The company does not admit liability by the issuance of this form. The issued form must be completed and returned within seven (7) days of receipt. No claim can be admitted unless Medical Certificate from a duly qualified and Registered Medical Practitioner, on the form annexed be furnished at expense of Insured. Claims Fax No : 6225 9887

Insured

Insured: _____

Age: _____ NRIC No: _____ Policy No: _____

Sum Insured: _____ Address: _____

Tel No/email: _____ _____

_____ Occupation : _____

Are you self employed? ☐Yes ☐No, If No, state employer's name and address: _____

_____

Do you have any other insurance that will cover this loss? ☐Yes ☐No If Yes, please provide details:

_____

Have you ever made a claim under any PA policy before? ☐Yes ☐No If Yes, state insurer, amount and date:

_____

_____

Details of Accident

Date: _____ Time: _____ am/pm Place: _____

State particulars of Accident in detail: _____

_____

_____

_____

_____

_____

_____

_____

_____

Name of hospital (or clinic) taken to: _____ ☐Inpatient ☐Outpatient

(Please fill in clinic's name if not hospitalized) Admitted on: _____ Discharged On: _____

State names of witnesses to the accident: _____

_____

State number of days you expect to be necessarily and entirely confined to House or Hospital, by Doctor's orders as the sole and direct result of the injuries sustained:

To House: _____ days To Hospital: _____ days

If still confined, state which: To House: _____ days To Hospital: _____ days

Do you expect in any way to attend to any part of your business or work during the above period. If so please describe as follows:

_____

_____

_____

Declaration

I hereby declare that I am the person referred to in the foregoing particulars, that I have received the injuries before described by violent, external and visible means. And I do further declare that I have always been uniformly sober and temperate in my habits, and that I was no way under the influence of drugs or intoxicating liquor when the accident occurred, and that I have not abstained from business or work, either totally or partially, longer than absolutely necessary in consequence of the said injuries, and that such injuries are the sole and direct cause of my disablement or loss.

I do hereby warrant the truth of the foregoing statements in every respect, and I agree that if I have made or in any further declaration the Company may require of me in respect of the said accident shall make, any false or fraudulent statement, or any suppression, concealment, or untrue avertment, the Policy shall be void as against the Company, and my right to compensation absolutely forfeited.

I hereby claim indemnity (compensation) as provided under my Policy as follows:

1) Temporary Partial Disablement: _____ Weeks @ _____ per week = _____

2) Temporary Total Disablement _____ Weeks @ _____ per week = _____

3) Permanent Partial Disablement _____

4) Permanent Total Disablement _____

5) Death _____

Important Notice: The insured person must, in the event of a claim, advise the company as to any other insurance that they may have covering the same risk.

Declaration: I hereby declare and warrant that all the answers given above to be true. I accept that insurers would be at liberty to deny liability in part or in full if the above written answers are false or inaccurate in any aspect.

Notice for Personal Data Protection Policy

By signing this form:

i) I/We acknowledge and consent to TMiS collecting, using, processing and disclosing to third party service providers and/or intermediaries, within or outside Singapore, my/our personal data for the purpose of processing and servicing my/our policies/claims;

ii) I/We declare and confirm that I/we have obtained the consent of the person(s) and/or nominee(s) named herein, where applicable, and that he/she/they has/have authorized me/us to disclose their personal data and to give consent on their behalf for the above collection, use, process and disclosure; and

iii) I/We acknowledge the detailed Privacy Policy Statement, governing the above, posted at www.tokiomarine.com.sg.

Signature : _____ Date : _____

Name : _____

MEDICAL REPORT - TO BE COMPLETED BY ATTENDING PHYSICIAN

Name of Patient: _____

NRIC No.: _____ Profession/Occupation: _____

Are you the patient's usual medical doctor? ☐Yes ☐No
Have you attended him for any illness or accident before? ☐Yes ☐No

If Yes, state for what and when _____

_____

How was the present accident caused? _____

After the accident, the first treatment was 1) When? _____

2) Where? _____

Was patient in your opinion, perfectly sober at the time of accident? ☐Yes ☐No

State as fully as possible the nature and extent of injures sustained : _____

_____

_____

Are injuries on the right or left side? _____

In your opinion, are the injuries sustained in line with the accident that patient described? ☐Yes ☐No

Is the patient now or was he at the time of accident, suffering from or affected by any physical infirmity, disease, or illness, irrespective of the injuries? ☐Yes ☐No

If Yes, 1) state nature _____

2) extent it impede the recovery of patient _____

Is patient suffering from or does he suffered from any cardiac affection, gout, rheumatism, or fits of any kind? ☐Yes ☐No

Are you aware of anything in the previous medical history of the patient which might have contributed directly or indirectly, to the occurrence of the accident, or which may be likely in any way to retard his recovery from it? _____

_____

_____

State whether the patient is confined to bed ☐Yes ☐No

Is patient prevented from following his usual business or occupation as a direct result of his injuries. ☐Yes ☐No

How long in your opinion will patient be so disabled? _____

State as clearly as possible his present condition _____

_____

Signature of Physician/Surgeon : _____ Date : _____

Name & Designation : _____

Name & address of clinic/hospital : _____