Liberty Insurance

www.libertyinsurance.com.sg

Claims Form

Personal Accident

Please complete all sections to facilitate the processing of your application. This form is issued without admission of liability and it must be completed and returned to us immediately, whether or not a claim is made. Any documentary proof or report required by liberty shall be furnished at the expense of Policyholder or Claimant.

Information of Policyholder

Name of Policyholder:	**Policy No.:**	
Is Policyholder GST – registered?	❑ Yes	❑ No
If Yes, is Policyholder allowed to claim GST on the Insurance Premium paid?	❑ Yes	❑ No
Email:	**Contact No.:**	
Mailing Address:		
Postal Code ( )		

Information of Claimant

Name of Claimant:	**Occupation:**	
Mailing Address:		
Postal Code ( )		
NRIC/FIN No.:	**Contact No.:**	
Email:		

Details of Accident/Injury

Date of Accident/Injury:	**Time of Accident/Injury:**	**Place of Accident/Injury:**
How did the Accident happen?		
Describe the Nature of Injuries sustained:		

Please provide:

a) Original medical bills and/or medical reports/memo from attending doctor stating the Nature of the Injury if you are treated as an outpatient as a result of an accident

b) Original hospital final bill and inpatient discharge summary/medical reports if you are hospitalized as a result of an accident

Bank Account Information for Electronic Transfer

Name of Bank:	Bank Code:	Branch Code:
Bank Account No.:	Name of Bank Account Holder:	

I agree to hold Liberty Insurance Pte Ltd harmless and that it is fully and finally discharged of its obligations once it has made payment to the bank and bank account number given above.

PERSONAL DATA PROTECTION

Liberty Insurance Pte Ltd ("**Liberty**") takes the responsibilities under Singapore's Personal Data Protection Act 2012 (the "**PDPA**") seriously. We also recognize the importance of the personal data you have entrusted to us and believe it is our responsibility to properly manage, protect and process your personal data.

The personal data which Liberty collect from you in this claims form, that previously collected and/or collect in the future, may be collected, used, disclosed and/or processed for one or more of the following purposes:

a) processing and/or dealing with any claims including the settlement of claims and any necessary investigations relating to the claims
b) investigating the accident and/or your claims
c) carrying out and/or dealing with your instructions or responding to any enquiries by you
d) conducting research, in-house training, analysis and development activities (including but not limited to data analytics, surveys (such as insurance survey, customer service survey, branding survey), branding campaign, quality assurance, product and service development and/or profiling) to improve Liberty's services or products and/or to enhance the product or service for your benefit
e) administering your claims (including the mailing of correspondence, statements, invoices, reports or notices to me, which could involve disclosure of certain personal data about me to bring about delivery of the same as well as on the external cover of envelopes/mail packages)
f) investigating fraud, misconduct, any unlawful action or omission, whether relating to your claims or any other matter relating to your claim(s), storing, hosting, backing up (whether for disaster recovery or otherwise) of your personal data, whether within or outside Singapore
g) recover debt owed to us
h) complying with applicable laws in administering, processing, handling and/or dealing with your claims
i) reinsurance administration/transactions
j) Any other purposes which we notify you of at the time of obtaining your consent

(collectively the "**Purposes**")

Liberty may/will also be collecting from sources other than yourself, personal data about you, for one or more of the above Purposes, and thereafter using, disclosing and/or processing such personal data for one or more of the above Purposes.

You also consent that any other Insurer may/can collect from Liberty (and that Liberty may disclose to them), use, disclose (including disclose to Liberty) and/or process your personal data for one or more of the above Purposes.

Your personal data may/will be disclosed by Liberty and/or any of the other Insurers to third parties, whether located within or outside Singapore, for one or more of the above Purposes, as such third parties, would be processing your personal data for one or more of the above Purposes. In this regard, you hereby acknowledge, agree and consent that Liberty may/are permitted to disclose your personal data to such third parties (whether located within or outside Singapore) for one or more of the above Purposes and for the said third parties to subsequently collect, use, disclose and/or process your personal data for or more of the above Purposes including engaging and disclosing to their third party service providers or agents (whether sited in or outside of Singapore) to do so, and the aforementioned collection, use, disclosure and processing activities and permissions in this sub-clause apply to these third party service providers or agents and any third party service providers or agents they in turn engage and so on. Without limiting the generality of the foregoing, such third parties include:

PERSONAL DATA PROTECTION

a) Liberty's associated or affiliated organizations or related corporations
b) any of Liberty's agents, contractors or third party service providers who process your personal data on Liberty's behalf including but not limited to those which provide administrative or other services to Liberty such as mailing houses, telecommunication companies, information technology companies, data storage or hosting companies, data centres, disaster recovery service providers, banks, medical professional, reinsurers, workshops
c) lawyers/law firms, legal process participants and their advisors
d) General Insurance Association Singapore ("GIA")
e) Monetary Authority of Singapore ("MAS")
f) any third party in connection with any proposed or actual reorganization, merger, sale, joint venture, assignment, transfer or other disposition or all or any portion of Liberty's business, assets or stock (including in connection with any bankruptcy or similar proceedings); and/or
g) third parties to whom disclosure by Liberty is for one or more of the Purposes and such third parties would in turn be collecting and processing your personal data for one or more of the Purposes

I/We have read and I/we accept the terms of Liberty's Data Protection Policy at www.libertyinsurance.com.sg/data-protection-policy/.

DECLARATION

1) I declare that I have complied with the conditions and warranties (if any) of the Policy and in no manner deliberately caused the said loss or damage or exaggerated the claim or sought unjustly to benefit by any fraud or willful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty Insurance reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.

   I authorize the release of any medical information necessary to process this claim.

1) The personal data of the individuals (the "**3rd Party Individuals**") which I/we am/are providing to you in this form are accurate and complete. I/we warrant that I/we have obtained consent from the 3rd Party Individuals (or if lacking in legal capacity, his/her legal representatives, guardians or parents as the case may be) for Liberty to collect, use and disclose his/her personal data for the above purposes and on the terms in this document, and as if the said data are about me/us. I/We will inform Liberty of any changes to the data as soon as practicable.
2) I/We have read and agree to the above, including as to how my personal data may/will be collected, used, disclosed and processed by Liberty and others as stated above.

_____ _____

Date Signature of Claimant

_____ _____

Date Signature of Policyholder & Company Stamp

Medical Information (to be completed by attending physician)

Name of Patient: _____	**NRIC/FIN No.:** _____	
Date when the Patient first consulted you: _____		
Is condition due to:	❑ Sickness	❑ Injury
Presenting Complaints: _____		
How long had the Patient been experiencing these symptoms? _____		
Was the Patient referred by another physician? If Yes, state Name, Address & Contact No.: _____	❑ Yes	❑ No
State your diagnosis of the illness/ injuries: _____		
Describe in detail the injuries sustained, indicating the part of the body injured and the types of injury (e.g. fracture, cut, bruise, etc.): _____		
Has the same part been injured previously? If Yes, please give details _____	❑ Yes	❑ No
The cause of the Accident, so far as known to you (state your diagnosis): _____		
Are you the Patient's usual Medical Attendant? i. If Yes, how long have you known him/her and for what reasons were the medical treatments rendered? _____ ii. If No, was the Patient referred to you by a general practitioner? If so, please indicate his/her name and address. _____	❑ Yes	❑ No
Has the Patient ever experienced any pre-existing condition or symptom at the injured area(s) stated above prior to the accident? If Yes, please provide details on: i. Nature of pre-existing condition or symptom _____ ii. How long do you feel the symptoms lasted? _____	❑ Yes	❑ No
Are the Patient's symptoms: i. Due exclusively to the accident? If No, please clarify. _____	❑ Yes	❑ No
ii. Traceable to disease, infirmity or any other cause? If so, please clarify. _____	❑ Yes	❑ No

Have you any reason to suppose that the patient was under the influence of intoxicants at the time of the accident?	❑ Yes	❑ No
Is there any other information, professional or otherwise, that you consider should be made known to us? _____		
Are you claiming from any other insurance company or other sources in respect of this injury? If Yes, please state:	❑ Yes	❑ No
Name of Insurance Company: _____	**Policy No.:** _____	
Amount of Compensation: S$_____	**Date Insurance Effected:** _____	
Have you ever made a claim against any insurer previously? If Yes, please state:	❑ Yes	❑ No
Name of Insurance Company: _____		
Date of the Accident: _____	**Nature of Injury:** _____	**Amount of Compensation:** S$_____
Is Patient sill under your care for this condition?	❑ Yes	❑ No
Give details of any circumstances, such as physical defects or medical history which may have ever contributed to the condition/ symptom and/or lengthen the period of disability _____		
Whether the injuries sustained will result in any permanent disablement/ incapacity. If so, please advise percentage of disablement/ incapacity _____		

I hereby certify that I have personally examined and treated the Patient for the above illness/injuries and that the facts as given above present my opinion of the patient's condition.

_____
Date

_____
Signature of Physician
Name:
Contact No.:
Company Stamp: