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

Work Injury Compensation Accident Report Form

(the company does not admit liability by the issuance of this form)
Particulars of every accident to be furnished and signed by the employer.

FGA Claims Fax No (65) 6225 9887

Employer Information

Policyholder: _____

_____

Policy No: _____

Address: _____

_____

Tel No/email: _____

_____

Contact Person: _____

Business: _____

Total Number of employees: _____

Are you GST Registered? ☐Yes ☐No

Agency/Broker: _____

Do you have any other insurance that will cover this loss?

☐Yes ☐No If Yes, please provide details:

_____

The injured person

Name:_____

NRIC/Passport/Work Permit No:_____

Nationality: _____

Age: _____ Sex: ☐Male ☐Female

Local Address: _____

_____

No of working days per week : _____

Occupation of injured: _____

What was injured doing when accident happened:_____

_____

Is injured your employee? ☐Yes ☐No
If Yes, employment date/years of service: _____
If No, who is injured's employer & relationship with you

_____

_____

Has injured been medically examined: ☐Yes ☐No
If No, why? _____

Name of hospital (or clinic) taken to: _____

_____ ☐Inpatient ☐Outpatient
(Please fill in clinic's name if not hospitalized)

Admitted on: _____ Discharged On: _____

Has injured returned to work?

☐ Yes on _____

☐ No, estimated period of disablement _____
Can injured do partial work? ☐Yes ☐No

Are you satisfied that injured met with a bona fide accident of employment? ☐Yes ☐No

Nature/Region of Injury: _____

_____

_____ on the ☐ Left ☐ Right

For fatal accident:

1) State official cause of death : _____

_____

2) Will an enquiry be held?

☐Yes (please supply copy of enquiry notes)
☐No (please supply post mortem or medical certificate)

Additional Information

For fatal cases and cases where injured is unable to take care of his/her daily affairs, please provide a separate listing stating dependent's name, addresses, relationship, age, and occupation.

The Accident

Date: _____ Time:_____

Place:_____

When were you notified of accident? _____

Who notified you of accident? _____
(If in writing, please attach to this form)

Date injured actually ceased work _____

State the general nature of work going on when the accident happened? _____

_____

_____

Explain the accident in detail:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

If machinery used, state what machinery _____

_____

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

Was injured guilty of any misconduct or disobedience to order or rules? ☐Yes ☐No
If Yes, give details _____

_____

Whose neglect caused accident? _____

_____

Any witnesses to the accident? ☐Yes ☐No

Witness Name/Employer/Tel: _____

_____

Was accident reported to Ministry of Manpower, Commissioner for Labour? ☐Yes ☐No
If Yes, please attach a copy of ireport or Form A

If No, reasons: _____

General Documents Required:
a) Claim Form duly completed and signed
b) Accident Report Form A or ireport with MOM
c) Police Report (if applicable)
d) Original medcal certificate and medical bills
e) NRIC/Work Permit/Passport (Copy with photo shown)
f) All third party correspondences, unanswered
g) Relevant contracts to show relationship between insured and subcontractor
h) Salary Vouchers (12 months before date of accident)
Please submit above as applicable. We will write to you separately for further information as necessary.

Statement of Wages
Wages which have fallen due for payment to the injured in the employ of insured for 12 months prior to date of accident, or wages earned during such shorter period as injured may have been in insured's service, stating the date in which he was engaged.

Month/Year	Basic Wages	Overtime, Bonus, Value of free quarters, Other allowances
Total		
	Total including all allowance	

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/we hereby declare and warrant that all the answers given above to be true. I/we 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, or intermediaries, within or outside Singapore, my/our personal data for the purpose of processing/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.

Employer's Signature
& Co Stamp : _____

Name : _____

Date : _____

Please return completed claim form to: Tokio Marine Insurance Singapore Ltd, 20 McCallum Street #09-01, Tokio Marine Centre, S'pore 069046. Fire & GA Claims Dept, Fax : 6225 9887
Please attach another piece of paper if space provided is insufficient.