

# Tenet Insurance Company Ltd

(A member of Sompo Japan Group)  
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Company Registration No. 195700067Z http://www.tenetinsurance.com



## PERSONAL ACCIDENT CLAIM FORM

### Important Notice :

- 1 The acceptance of this form is NOT an admission of liability on the part of the Company.
- 2 All documents provided to substantiate your claim must be original documents.
- 3 All medical reports must be submitted at the claimant's expense before a claim can be admitted.

AGENCY: \_\_\_\_\_ POLICY NO: \_\_\_\_\_

Have you notified us of this claim earlier?  No  Yes by email / fax / telephone call to \_\_\_\_\_

Please state any reference number assigned to you earlier: Claim no / Temporary ref no \_\_\_\_\_

### Useful notes:

- a) Medical and TCM bills must indicate a breakdown of the expenses incurred (consultation and medication prescribed). Do not submit receipts as these will not show enough information for the claim to be assessed.
- b) The doctor's diagnosis must be clearly stated especially for claims made under extended benefits, for example, food poisoning, insect bites.

### 1. INSURED'S PARTICULARS

a. Name of Insured \_\_\_\_\_

b. Address \_\_\_\_\_

c. Residence / Business Telephone Nos.

(Res) \_\_\_\_\_ (O) \_\_\_\_\_ (HP) \_\_\_\_\_

d. Email \_\_\_\_\_ e. Business / Occupation \_\_\_\_\_

### 2. CLAIMANT'S PARTICULARS

a. Name and nature of relationship of Claimant to Insured \_\_\_\_\_

Insured  Dependant of Insured  Employee  Dependant of Employee

NRIC / Passport No. of Claimant: \_\_\_\_\_

b.  Female  Male / Age \_\_\_\_\_ Date of birth \_\_\_\_\_ /  Married  Single

c. If Dependant state relationship to Insured / Employee

Husband / Wife  Son  Daughter  Parent

d. Is Dependant employed?  No  Yes Occupation : \_\_\_\_\_

e. If Employee, state date of employment and occupation

Date: \_\_\_\_\_ Occupation: \_\_\_\_\_

### 3. PARTICULARS OF ACCIDENT

Please attach as applicable :

- 1) Medical Report
- 2) Medical Bills and Certificates
- 3) Police Report
- 4) Death Certificate / Letter of Administration

a. Date / time of accident \_\_\_\_\_ b. Location \_\_\_\_\_

c. Were you perfectly sober at the time of the accident?  Yes  No

d. State name and address of any person(s) who witnessed the accident

Name : \_\_\_\_\_ Contact: \_\_\_\_\_

Address : \_\_\_\_\_

e. In respect of the accident are you entitled to receive compensation from any other source?  Yes  No

If yes, state: From what source : \_\_\_\_\_

To what extent : \_\_\_\_\_

f. Have you ever made a claim for compensation in respect of accidental injury from any Insurance Company?  
 Yes     No    If yes, give particulars.

g. State how accident occurred and what claimant was doing at the time. **Attach Police Report if applicable.**

h. Please state as precisely as you can the injuries sustained, indicating the part of the body injured and the type of injury (eg, fracture, cut, bruise etc.)

i. Date returned / expected to return to work \_\_\_\_\_

j. If still receiving treatment, please state nature of treatment and next scheduled medical appointment

\_\_\_\_\_ Date of next Appointment: \_\_\_\_\_

k. Amount claimed \_\_\_\_\_

l. Will there be any more bills to be submitted?     Yes     No    \_\_\_\_\_

**D. PAYMENT DETAILS (if claim falls within terms and conditions of the policy)**  
**For GIRO payments above \$3,000 we require a Direct Credit Authorisation Form acknowledged by your bank.**

1. Please confirm payee name if claim is payable \_\_\_\_\_

**Note:** If payee is different from claimant or is not listed in the policy please provide a Letter of Authorisation.

2. Tick the method of payment you prefer     By Cheque     By GIRO

2a. If payment is requested by GIRO, please advise bank details:

Bank / Branch: \_\_\_\_\_ Account Number: \_\_\_\_\_

Account Name: \_\_\_\_\_ I.C./Passport Number: \_\_\_\_\_

Signature of Payee: \_\_\_\_\_

Note: All payment(s) made to this account is based on information provided by you and the Company shall not be liable in respect of any disputes and/or loss and/or damage that may arise out of this transaction.

**We may request for your doctor to complete the Medical Certificate of Treatment (Personal Accident) Form if we require further clarification of your claim.**

**DECLARATION AND AUTHORISATION - to be signed by the claimant**

I declare that the particulars stated above are true and correct and I understand that if I have in this or in any further declaration in respect of this claim, made any false or fraudulent statement or suppress conceal or falsely state any material fact whatsoever my claim may be refused. I/We further authorise the Company to treat the submission of this form as my/our making a claim under my/our policy.

I hereby authorize any hospital physician, other person who has attended or examined me, to furnish to the company, or its authorized representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photocopy of this authorisation shall be considered as effective and valid as the original.

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name

\_\_\_\_\_  
NRIC Number