

Tenet Insurance Company Ltd

(A member of Sompo Japan Group)
50 Raffles Place, #05-01/06 Singapore Land Tower Singapore 048623
Tel: 6221 2211 Fax: 6221 3302
Company Registration No. 195700067Z <http://www.tenetinsurance.com>



WORK INJURY COMPENSATION CLAIM FORM

Important Notice :

- 1 This form is issued without admission of liability.
- 2 All **original** bills, certificates, supporting documents including **Medical Report, Inpatient Discharge Summary, Referral for Continuation of Treatment Form, payslips for past twelve (12) months** should be provided to substantiate your claim.
- 3 A copy of the **i-report** submitted by the employer to the Ministry of Manpower (MOM) must be sent to the Insurance Company together with this Claim Form.
- 4 As per Work Injury Compensation Act, every accident involving your employee(s) must be reported to the Ministry of Manpower within **ten (10) days** of the accident otherwise you may be punished with a fine. You must also submit your claim form to the Insurer as soon as possible so as not to prejudice your claim.
- 5 If the accident is the subject of a claim under Common Law, you are to forward to the Company all letters that you have or may receive from the lawyers for the injured person and you must not admit liability in any manner.

Agency: _____ Policy / Certificate No: _____

1. INSURED DETAILS

a. Name of Insured

b. Address

c. Business

d. Name of Contact Person / Contact No.

Contact Person: _____ Contact No: _____

Email _____

e. Company Details

Total No. of Employees: _____ Total Earnings for the twelve (12) month period prior to the accident: _____

f. Has the accident been reported to MOM? Yes No

If yes, please provide us with a copy of the completed MOM claim form

2. INJURED PERSON DETAILS

a. Name

b. Residential Address

c. Contact No.

(Res) _____ (HP) _____ Email _____

d. Sex / Age: Female Male / Age: _____

e. Marital Status: Single Married Others: _____ State number of dependants if any _____

f. Nationality / Identity Card or Passport Number (Please provide copy of work permit)

g. Date of Employment

h. State injured person's occupation

i. Average Monthly or Daily Wage

\$ _____ per month / day

j. On what work was the injured person engaged in at the time of the accident?

3. IS THE INJURED PERSON IN YOUR DIRECT EMPLOY Yes No If 'No', please complete this section

Name of direct employer _____

Address of direct employer _____

Contact No. of direct employer: _____

Annual WC Insurer of direct employer: _____

4. TREATMENT DETAILS / STATUS OF INJURED PERSON

a. Name of hospital / clinic taken to

b. Admission Details

Out-patient In-patient Day Surgery Admit on _____ Discharged on _____ No. of Days _____

c. Has injured person returned to work? Yes No

If yes, state date return to work, if no, state when medical leave ends

d. Is the injured person still in your employ? Yes No

e. Is the injured person able to do partial work? Yes No

f. What is the probable period of disablement (approximate)?

g. Was the injured person employed on a 5-day week basis at the time of accident? Yes No

5. DETAILS OF THE ACCIDENT

a. Date and time of accident

Date: _____

Time: _____

b. Location where accident occurred

c. On what date did you receive notice of accident and from whom?

d. Was anyone superintending the work the injured person was engaged in? Yes No

If yes, state name, occupation and contact number

Name: _____

Occupation: _____

Contact No: _____

e. Did the accident involve machinery or gearing? Yes No

If yes, was it fenced or guarded Yes No

was it being cleaned whilst in motion Yes No

f. Describe exactly how the accident happened? If insufficient space please use Section E on last page.

g. What was the general nature of the contract or work going on?

h. State nature of injury in detail

i. If the accident is a fatal one, state whether an enquiry was conducted

j. Was the injured person under the influence of alcohol or drugs at the time of the accident? Yes No

k. Was he guilty of any misconduct or disobedience to orders or rules? Yes No

If so, please give full particulars.

l. State through whose neglect the accident occurred, if any.

m. Was a third party involved? Yes No

If yes, please provide name, company and contact no.

Name: _____ Contact No: _____

Company: _____

n. State the names, occupation and contact numbers of any persons who witnessed the accident

Name	Occupation	Contact Numbers

6. MONTHLY EARNINGS DETAIL

a. The object of this Section is to ascertain the exact Monthly Earnings of the injured person. It is essential that it should be carefully and correctly filled in. If the injured person has been absent from work at any time during the period of employment, please state the period and the cause.

b. If the injured person has been employed for more than a period of ONE (1) year, the Employer MUST SHOW the whole of the previous years wages paid to the employee including payment for overtime, bonus and other allowances.

