

WORK INJURY COMPENSATION CLAIM FORM

(This claim form is to be used only if an iReport has already been lodged with the Ministry of Manpower)

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 workman and you must not admit liability in any manner.

Agency: _____ Policy / Certificate No: _____

1. INSURED DETAILS

a. Name of Insured _____

b. Name of Contact Person / Contact No. _____

Contact Person: _____ Contact No: _____

c. 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. Address in Singapore _____

c. Contact No. _____ (HP) _____ (res) Email address _____

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 _____

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

b. Has injured person returned to work? Yes No

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

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

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

5. DETAILS OF THE ACCIDENT

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

b. 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: _____

c. State nature of injury in detail

d. 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 injured person including payment for overtime, bonus and other allowances.
- c. If the injured person has been employed for less than one (1) year, please complete statement of wages IN THE PRESENT EMPLOYMENT immediately prior to the date of the accident, stating the date on which he was engaged.

	MONTH	No. of Working Days	Gross Monthly Earnings [Excluding Bonus]		Annual Wage Supplement/Bonus Paid during Past Twelve (12) Months	
			\$	cts	\$	cts
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
TOTAL						
MONTHLY AVERAGE						

We/I hereby declare that the above statements are true to the best of our/my knowledge and belief and we/I undertake to advise the Company promptly of all developments in connection with the claim. We/I further authorise the Company to treat the submission of this form as our/my making a claim under my/our policy.

Signature of Insured (with Company's Stamp)

Date

Name of Authorised Signatory

Designation