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## PERSONAL ACCIDENT CLAIM FORM

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.

### 1. THE POLICYHOLDER

Name: \_\_\_\_\_ NRIC/Passport No: \_\_\_\_\_

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

Contact Telephone No.: \_\_\_\_\_ Policy No.: \_\_\_\_\_

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

Are you GST registered? Yes / No    If yes, are you allowed to claim the GST on the Insurance Premium Paid? Yes / No.

### 2. NATURE OF CLAIM – I am making a claim for the following (please tick):

#### PACare Policy

- Section 1: Accidental Death
- Section 2: Permanent Disablement (Total & Partial)
- Section 3: Double Indemnity for Death/Permanent Disablement due to:
  - (a) accident whilst traveling as a passenger in any public conveyance
  - (b) landslide, flood, explosion or fire
- Section 4: Temporary Total Disablement
- Section 5: Temporary Partial Disablement
- Section 6: Daily Hospital Cash
- Section 7: Compassionate Cash Relief in the event of fatal accident
- Section 8: Accidental Medical Expenses
- Section 9: Double Medical Indemnity due to:
  - (a) accident whilst traveling as a passenger in any public conveyance
  - (b) landslide, flood, explosion or fire
- Section 10: Chinese Physician Medical Expenses
- Section 11: Emergency Medical Evacuation whilst on overseas trip
- Section 12: Repatriation of Mortal Remains whilst on overseas trip

#### FamilyCare Policy

#### Personal Accident Policy

- Death
- Permanent Disablement (Scale I)
- Permanent Disablement (Scale II)
- Temporary Partial Disablement
- Temporary Total Disablement
- Medical Expenses
- Chinese Physician Medical Expenses
- Hospital Allowance
- Family Income

**3. Particulars of Accident/Injury**

Date of Accident/Injury: \_\_\_\_\_ Time of Accident/Injury: \_\_\_\_\_

Place of Accident/Injury: \_\_\_\_\_

How Accident Happened: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe the Injury(ies): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Please provide:*

- (a) *original medical bills and/or medical reports/memo from the 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 report if you are hospitalised as a result of an accident.*

**5. Particulars relating to Temporary Total Disablement and Temporary Partial Disablement**

(a) Details of attending doctor.

Name of Doctor: \_\_\_\_\_

Name and Address of Clinic: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(b) Period of Temporary Total Disablement (i.e. **entirely** prevented from engaging in or giving attention to your profession or occupation).

From: \_\_\_\_\_ To: \_\_\_\_\_

(c) Period of Temporary Partial Disablement (i.e. **substantially** prevented from engaging in or giving attention to your profession or occupation).

From: \_\_\_\_\_ To: \_\_\_\_\_

*Please attach Original Medical Certificate(s).*

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 sought unjustly to benefit by any fraud or wilful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Policyholder)