



Liberty Insurance Pte Ltd
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WORK INJURY COMPENSATION CLAIM FORM

THIS FORM IS ISSUED WITHOUT ADMISSION OF LIABILITY, AND IT MUST BE COMPLETED AND RETURNED TO THE COMPANY IMMEDIATELY, WHETHER OR NOT A CLAIM IS MADE.

A. THE POLICYHOLDER

1. Name _____
2. Policy No. _____ Expiry Date _____
3. Business _____
4. Address _____
5. Telephone No. _____ Fax No. _____
6. Total No. of Employees _____ Name of Agent/Broker _____
7. Name of the Main Contractor (if the policyholder is not the main contractor) for this Project

Name of insurer(s) _____ Policy No. _____

B. THE INJURED EMPLOYEE

1. Name _____ Sex _____ Age _____
2. Citizenship _____ NRIC / Passport No. _____
3. Local address _____ Contact No _____
4. Occupation _____ Date entered your service _____
5. Is the employee your relative? YES / NO. If YES, state relationship _____
6. Was the employee engaged in this occupation when the accident occurred? YES / NO If NO, give details

7. Did the employee suffer from any physical defect/disability before the accident? YES / NO If YES, give details

8. Is the employee your direct employee? YES / NO If NO, give details of direct employer:
Name _____ Tel. No. _____ Fax No. _____
Address _____
9. Is there any other policy(ies) covering the employee in respect of this accident? YES / No. If YES, give details:

C. DETAILS OF THE ACCIDENT

- 1. Date _____ Time _____ a.m. / p.m.
- 2. Date the accident was reported to you (if in writing, attach correspondence) _____
- 3. Place & address where accident occurred _____
- 4. Describe how the accident occurred _____

- 5. Was the employee under the influence of intoxicating liquor / drugs? YES / NO, If YES, give details _____
- 6. Was the employee injured due to his / her own misconduct or failure to follow instructions? YES / NO. If YES, give details _____
- 7. Was anyone supervising the employee at the time of the accident? YES / NO. If YES, give details of supervisor:
Name _____ Designation _____
Address _____ Tel. No. _____
- 8. Was the accident reported to the Ministry of Manpower? YES / NO If YES, date reported _____
Attach a copy of the MOM i-Report to this form.

D. RESPONSIBILITY / WITNESSES

- 1. Was another person, in your opinion, responsible for the Accident? YES / NO
- 2. If YES, give details: Name _____
Home Address _____
Office Address _____
Occupation _____ NRIC No. _____
Home Tel. _____ Office Tel. _____ Mobile No. _____
Reasons why he / she was responsible _____

- 3. Was there a witness / witnesses to this event? YES / NO If YES, give details:
Name _____ NRIC No. _____
Address _____
Home Tel. _____ Office Tel. _____

E. INJURIES SUSTAINED FROM THE ACCIDENT

1. Details of the injuries, including the nature and the region _____

2. Date the employee ceased work _____

3. Name of Hospital / Clinic the employee was treated _____

IN PATIENT / OUT PATIENT. Date discharged from hospital _____

4. Is the employee still undergoing medical treatment? YES / NO

5. Has the employee returned to work? YES / NO If YES, date _____

If NO, when is the employee likely to be able to return to work _____

6. In **DEATH cases**, please furnish:

- (a) A copy of the Death Certificate, Post Mortem report and police report (if any).
- (b) List of Deceased's dependants, stating names, addresses, ages, relationships and occupations.
- (c) Date of the coroner's inquest, if any.

F. EARNINGS OF THE INJURED WORKER

The "earnings" of an injured workman include his wages, food allowance, housing allowance, overtime, bonus or annual wage supplement but do not include travelling allowance, employer's share of the CPF contributions or pension or money paid to cover any special expenses incurred by him by nature of his employment.

No. of working days per week _____

Month	Gross Monthly Earnings (Excluding Bonus)	Annual Wage Supplement/ Bonus
Total		
Average	A1	A2

Total Average Earnings (A1 + A2) = _____

IMPORTANT NOTICE

1. The injured employee is required to inform his employer of the accident as soon as practicable
2. The employer is required to report the accident to MOM within the stipulated time period as well as notify his Insurer(s).

Work Related Incident Results In:	Reporting Timeline
Death of an employee	Within 10 days of the occurrence
Incapacity that renders the employee unfit for work for more than 3 consecutive days or is admitted in a hospital for at least 24 hours	Within 10 days of the occurrence
Occupational disease to an employee	Within 10 days of receiving the written diagnosis

Failure to report a work-related accident is an offence which carries a fine up to S\$5,000 for a first-time offence, and a fine of up to S\$10,000 and/ or jail term of up to six months for subsequent offences

3. If the accident is a subject of claim under Common Law, you are to forward to the Company all letters that you have received, or may receive, from the lawyers of the injured person and you must not in any circumstances admit liability in any manner.

DECLARATION

I / We declare that the information shown on this Form is true and correct to the best of knowledge and that I / We have not concealed any information relating to this accident.

Authorised Signature of Policyholder : _____
(With Company Stamp)

Name of Signatory : _____

Designation : _____

Date : _____