Liberty Insurance
Member of Liberty Mutual Group

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. Any documentary proof or report required by Liberty Insurance shall be furnished at the expense of the Policyholder or Claimant.

POLICYHOLDER INFORMATION

Name:	Is policyholder GST- registered? ☐ YES ☐ NO If yes, is policyholder allowed to claim the GST on the Insurance Premium paid? ☐ YES ☐ NO
Address:	Policy No:
Email Address:	Telephone No:

CLAIMANT INFORMATION

Name (Mr/Miss/Mrs/Mdm):	NRIC/Passport No:
	Telephone No:
Address:	Email Address:
	Occupation:

DETAILS OF ACCIDENT/INJURY

Date & Time of Accident	Place of Accident:
How did accident happen?	
Describe the nature of injuries sustained:	

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 hospitalized as a result of an accident.

BANK ACCOUNT INFORMATION (for *GIRO Claims Processing*)

Name of Bank:	Bank Code:	Branch Code:
Bank Account No:	Name of Account Holder:	

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 exaggerated the claim or sought unjustly to benefit by any fraud or willful misrepresentation and that the information shown on this Form is true and that I have not concealed any information relating to this claim. I understand Liberty Insurance reserves the right to repudiate the claim if it is later proven false or intentionally omitted by me.

I authorize the release of any medical information necessary to process this claim.

Signature of Claimant   ***Authorised Signature & Company Stamp of Policyholder***

Date   ***Date***

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MEDICAL INFORMATION *(to be completed by the attending physician at the expense of the policyholder)*

Name of Patient:	NRIC/Passport No:
Date when the patient first consulted you:	Is condition due to: ☐ Sickness ☐ Injury
Was the patient referred by another physician? ☐ YES ☐ NO If YES, state name, address & telephone number:	State your diagnosis of the illness/injuries:
Presenting complaints:	
How long had the patient been experiencing these symptoms?	

Investigations done?	☐ YES ☐ NO	If YES, please provide investigation result.
Special diagnostic procedures?	☐ YES ☐ NO	If YES, please specify:
X Ray?	☐ YES ☐ NO	If YES, please provide investigation result.
Surgery?	☐ YES ☐ NO	If YES, please specify:
Did injury require hospitalization?	☐ YES ☐ NO	If YES, please specify date of admission:
Is patient still under your care for this condition?	☐ YES ☐ NO	

Give details of any circumstances, such as physical defects or medical history which may have contributed to the condition/symptom and/or lengthen the period of disability.

Whether the injuries sustained will result in any permanent disablement/incapacity. If so, please advise percentage of disablement/incapacity

I hereby certify that I have personally examined and treated the patient for the above illness/injuries and that the facts as given above present my opinion of the patient's condition.

Signature of Physician

Date

Name of Physician

Telephone Number

Company Stamp