Liberty Insurance
Member of Liberty Mutual Group

(FOR OFFICE USE) CLAIM REF: ____________________________

WORK INJURY COMPENSATION 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 shall be furnished at the expense of policyholder or claimant

POLICYHOLDER INFORMATION

Name:	Total Number of Employees:
Business:	Policy No:
	Expiry Date:
Contact Address:	Contact Telephone No:
Email Address:	Fax No:
Has premium been paid? YES / NO	Name of Agent/Broker:
Name of the Main Contractor (if the policyholder is not the main contractor) for this Project:	
Name of Insurer(s):	Policy Number:

THE INJURED EMPLOYEE

Name:	Sex:	Age:	Citizenship:
NRIC / Passport No:	Marital status:		
Local address:	Occupation:		
Contact Number:	Date Entered your Service:		

Is the worker your relative? YES / NO

If YES, state relationship:

Was the worker engaged in this occupation when the accident occurred? YES / NO.

If NO, give details:

Date the worker entered your service:	Did the worker suffer from any physical defect/disability before the accident? YES / NO If YES, give details:

Is the worker your direct employee? YES / NO

If NO, give details of direct employer:	Name:	Tel. No:	Fax No:
	Address:		

Is there any other policy(ies) covering the worker in respect of this accident? YES / No

If YES, give details:

DETAILS OF THE ACCIDENT

Date:	Place and Address of Accident:
Time:	

Date the accident was reported to you (if in writing, attach correspondence):

Describe how the accident occurred:

Was the worker under the influence of intoxicating liquor / drugs? YES / NO

If YES, give details:

Was the worker injured due to his / her own misconduct or failure to follow instructions? YES / NO

If YES, give details:

Was anyone supervising the employee at the time of the accident? YES / NO

If YES, give details of supervisor.		
Name:	Designation:	Tel No:
Address:		

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

RESPONSIBILITY / WITNESSES

Was another person, in your opinion, responsible for the Accident? YES / NO

If YES, give details.		
Name:	Occupation:	NRIC No:
Home Address:	Office Address:	
Home Tel:	Office Tel:	Mobile No:
Reasons why he / she was responsible:		

Was there a witness / witnesses to this event? YES / NO

If YES, give details.	
Name:	NRIC No:
Address:	Home Tel/Mobile No:
	Office Tel:

INJURIES SUSTAINED FROM THE ACCIDENT

Details of the injuries, including the nature and the region:

Date the worker ceased work:	Name of Hospital / Clinic the worker was treated:
Type: IN PATIENT /OUT PATIENT	Date discharged from hospital:

Is the worker still undergoing medical treatment? YES / NO

If NO, when is the worker likely to be able to return to work____

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, addressed, ages, relationships and occupations.
(c) Date of the coroner's inquire, if any.

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 Bonuses)	Annual Wage Supplement/Bonus
Total Average	A1	A2

Total Average Earnings (A1+A2) =

<u>**IMPORTANT NOTICE**</u>

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.

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.

Signature of policyholder
(With Company Stamp if applicable)

Date (dd/mm/yyyy)