

Please complete all sections to facilitate the processing of your application. 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.

Information of Policyholder

Name of Policyholder:	Policy No.:
_____	_____
Is Policyholder GST – registered?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, is Policyholder allowed to claim <u>GST</u> on the Insurance <u>Premium</u> paid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email:	Contact No.:
_____	_____
Mailing Address:	
_____ Postal Code ()	

Information of Claimant

Name of Claimant:	Occupation:
_____	_____
Mailing Address:	
_____ Postal Code ()	
NRIC/FIN No.:	Contact No.:
_____	_____
Email:	

Details of Accident/Injury

Date of Accident/Injury:	Time of Accident/Injury:	Place of Accident/Injury:
_____	_____	_____
How did the Accident happen?		

Describe the Nature of Injuries sustained:		

Please provide:

- Original medical bills and/or medical reports/memo from attending doctor stating the Nature of the Injury if you are treated as an outpatient as a result of an accident
- Original hospital final bill and inpatient discharge summary/medical reports if you are hospitalized as a result of an accident

Bank Account Information for Electronic Transfer

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

I agree to hold Liberty Insurance Pte Ltd harmless and that it is fully and finally discharged of its obligations once it has made payment to the bank and bank account number given above.

PERSONAL DATA PROTECTION

I give consent to Liberty Insurance Pte Ltd and third-parties including related entities, employees, agents, other insurers, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to myself or other individuals that I have furnished in the past, present & in the future, for one or more of the purposes described in Liberty's Data Protection Policy, including but not limited to considering whether to provide insurance, carrying out due diligence, pricing, administering and servicing my policies, communicating with me, renewals, reinsurance, collections, claims, accounting, audit, legal, compliance, research, analysis, information-sharing, surveys, data storage & backups. I have read and agreed to the full Policy at www.libertyinsurance.com.sg/data-protection-policy/. If there is any personal data relating not to myself but to other individuals that I have furnished in the past, present & in the future, I warrant that I have obtained prior consent from these data subjects (or if they are lacking in legal capacity, from their legal representatives, guardians or parents as the case may be) for Liberty Insurance Pte Ltd and its Appointees to collect, use and disclose their personal data for the abovementioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform Liberty of any changes to the personal data to my knowledge as soon as practicable.

DECLARATION

- 1) 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.

Date

Signature of Claimant

Date

Signature of Policyholder &
Company Stamp

Medical Information (to be completed by attending physician)

Name of Patient:	NRIC/FIN No.:
Date when the Patient first consulted you:	
Is condition due to:	<input type="checkbox"/> Sickness <input type="checkbox"/> Injury
Presenting Complaints:	
How long had the Patient been experiencing these symptoms?	
Was the Patient referred by another physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, state Name, Address & Contact No.:	
State your diagnosis of the illness/injuries:	
Describe in detail the injuries sustained, indicating the part of the body injured and the types of injury (e.g. fracture, cut, bruise, etc.):	
Has the same part been injured previously?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please give details	
The cause of the Accident, so far as known to you (state your diagnosis):	
Are you the Patient's usual Medical Attendant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. If Yes, how long have you known him/her and for what reasons were the medical treatments rendered?	
ii. If No, was the Patient referred to you by a general practitioner? If so, please indicate his/her name and address.	
Has the Patient ever experienced any pre-existing condition or symptom at the injured area(s) stated above prior to the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please provide details on:	
i. Nature of pre-existing condition or symptom	
ii. How long do you feel the symptoms lasted?	
Are the Patient's symptoms:	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Due exclusively to the accident? If No, please clarify.	
ii. Traceable to disease, infirmity or any other cause? If so, please clarify.	

Personal Accident

Have you any reason to suppose that the patient was under the influence of intoxicants at the time of the accident?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there any other information, professional or otherwise, that you consider should be made known to us? _____			
Are you claiming from any other insurance company or other sources in respect of this injury?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, please state: Name of Insurance Company: _____ Policy No.: _____			
Amount of Compensation: S\$ _____	Date Insurance Effected: _____		
Have you ever made a claim against any insurer previously?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, please state: Name of Insurance Company: _____			
Date of the Accident: _____	Nature of Injury: _____	Amount of Compensation: S\$ _____	
Is Patient still under your care for this condition?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Give details of any circumstances, such as physical defects or medical history which may have ever 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.

Date

Signature of Physician
Name:
Contact No.:
Company Stamp: