Liberty Insurance

www.libertyinsurance.com.sg

Claims Form

Work Injury Compensation

Document(s) for submission of claims to Liberty Insurance Pte Ltd

No.	Document Required	Attached
1	Claim Form – (Did accident arise out of and in the course of employment?)	☐
2	i-Report (if accident results in more than 3 days MC/hospitalization for more than 24 hours/death)	☐
3	Work Permit/Employee Pass (for foreign worker)	☐
4	Copy of Medical Report (if available)	☐
5	Inpatient Discharge Summary	☐
6	Original Medical Bills and Medical Leave Certificates	☐
7	Copies of wage payment vouchers for 12 Months prior to date of accident (e.g. Accident in January 2012, require wage payment voucher for January – December 2011)	☐
8	Please indicate the number of work days per week under "Earnings of Insured Worker" of the enclosed Claim Form	☐
9	Contract (with value) for job at accident site (where accident site is not insured premises)	☐
10	Contractual agreement between main contractor and sub-contractor (for project policy)	☐
11	Annual WICA policy of the other party (main/sub-con) insurer covering accident at worksite (for project policy)	☐
12	Police Report (where serious accident occurs resulting in fire, explosion collapse of building, etc.)	☐
13	Traffic Police Report (where it is a road traffic accident)	☐
14	Death Certificate and relevant reports (where accident results in death)	☐

Note: Additional documents may be requested as and when necessary.

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Work Injury Compensation

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.:**
Mailing Address:		Postal Code ( )
Email:		**Contact No.:**
Name of the Main Contractor (if Policyholder is not the main contractor) for this project:		**Nature of Business:**
Total No. of Employees:	**Name of Insurer(s):**	**Policy No.:**

Details of Injured Employee

Name of the Injured Employee:		**NRIC/FIN No.:**
Mailing Address:		Postal Code ( )
Contact No.:	**Age:**	**Citizenship:**
Marital Status:	**Gender:** ☐ Female ☐ Male	**Date Entered your Service:**
Occupation:		
Was the worker engaged in the occupation when the accident occurred? If No, please provide details:		☐ Yes ☐ No
Is there any other policy(ies) covering the worker in respect of this accident? If Yes, please provide details:		☐ Yes ☐ No
Is the worker your direct employee? If No, provide details of direct employer:		☐ Yes ☐ No
Name of Direct Employer:		**Contact No.:**

Details of Injured Employee

Mailing Address:

_____ Postal Code ( )

Details of Accident

Date of Accident:	**Time of Accident:**	**Place of Accident:**
_____	_____	_____

Address of Accident:

_____ Postal Code ( )

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

_____

Was the worker injured due to his/her 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, please provide details:

Describe how the accident occurred: _____

Name of Supervisor: **Designation:**

_____ _____

Address:

_____ Postal Code ( )

Contact No.:

_____

Was the accident reported to the Ministry of Manpower (MOM)? ☐ Yes ☐ No
(Attach a copy of the MOM i-Report)
If Yes, date reported:

_____

If the claim is reported too late, please provide the reason: _____

Responsibility/Witness(es)

Was another person, in your opinion, responsible for the Accident? ☐ Yes ☐ No
If Yes, please provide details:

Name: **NRIC/FIN No.:**

_____ _____

Home Address:

_____ Postal Code ( )

Office Address:

_____ Postal Code ( )

Reason(s) why he/she was responsible? _____

Responsibility/Witness(es)

Was there a witness(es) to this event? ☐ Yes ☐ No
If Yes, please provide details:

Name of Witness: **NRIC/FIN No.:**

_____ _____

Home Address:

_____ Postal Code ( )

Office Address:

_____ Postal Code ( )

Occupation: **Contact No.:**

_____ _____

Injuries Sustained from the Accident

Details of the injuries, including the nature and region:	**Date of when the worker ceased work:**
_____	_____
Name of Hospital/Clinic that the worker was treated:	**Date of 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? _____	
Are there any more medical bills or medical leave certificate forthcoming? ☐ Yes ☐ No	

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 inquire, if any

Earnings of 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 traveling 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 Earning (Excluding Bonuses)	Annual Wage Supplement/Bonus
Total Average	A1	A2
Total Average Earnings (A1 + A2)		

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