Liberty Insurance Pte Ltd
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Singapore 069428
Tel: 1800-LIBERTY (542 3789)
Reg. No. 199002791D | GST Reg. No. M2-0093571-3
www.libertyinsurance.com.sg

Claims Form – Personal Accident

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?	☐ No ☐ Yes
If yes, is Policyholder allowed to claim the GST on the Insurance Premium paid?	☐ No ☐ Yes
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 Accident happen? _____		
Describe the Nature of Injuries sustained? _____		

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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 hospitalised 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.
2. I authorise the release of any medical information necessary to process this claim.

_____ _____

Date Signatory of Claimant

_____ _____

Date Signatory of Authorised Policyholder and Company Stamp

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Medical Information (to be completed by the attending physician)

Name of Patient: _____		NRIC/FIN No.: _____
Date when the Patient first consulted you: _____	Is condition due to: ☐ Injury ☐ Sickness	How long had the Patient been experiencing these symptoms? _____
Presenting Complaints: _____		
Was the Patient referred by another physician? If yes, please provide details:		☐ No ☐ Yes
Name of Physician: _____	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? If yes, please provide details. _____		☐ No ☐ Yes
The cause of the Accident, so far as known to you (state your diagnosis): _____		
Are you the Patient's usual Medical Attendant? 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 be a general practitioner? If so, please indicate his/her name and address. _____		☐ No ☐ Yes
Has the Patient ever experienced any pre-existing condition/symptom at the injured area(s) stated above prior to the accident? If yes, please provide details on:		☐ No ☐ Yes

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i. Nature of pre-existing condition or symptom

_____

ii. How long do you feel the symptoms lasted?

_____

Are the Patient's symptoms:

i. Due exclusively to the accident? If no, please clarify. ☐ No ☐ Yes

_____

ii. Traceable to disease, infirmity or any other cause? If so, please clarify. ☐ No ☐ Yes

_____

Have you any reason to suppose that the Patient was under the influence of intoxicants at the time of the accident? ☐ No ☐ Yes

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? If yes, please state: ☐ No ☐ Yes

Name of Insurance Company: Policy No.:

_____ _____

Amount of Compensation: Date Insurance Effected:

S$ _____ _____

Have you ever made a claim against any insurer previously? If yes, please state: ☐ No ☐ Yes

Name of Insurance Company:

_____

Date of Accident: Nature of Injury: Amount of Compensation:

_____ _____ S$ _____

Is Patient still under your care for this condition? ☐ No ☐ Yes

Given 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.

_____

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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 are given above present my opinion of the Patient's condition.

Please turn to the next page for further details.

_____
Date

_____
Signatory of Physician

Name of Physician:

_____

Contact No.:

_____

Company Stamp:

_____