

Claim Form – Work Injury Compensation

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

Document Required	Attached
1. Claim Form – (Did <u>accident</u> arise out of and in the course of employment?)	<input type="checkbox"/>
2. I-Report (if accident results in more than 1 day MC/hospitalisation for more than 24 hours/death)	<input type="checkbox"/>
3. Work Permit/Employee Pass (for foreign worker)	<input type="checkbox"/>
4. Copy of medical report (if available)	<input type="checkbox"/>
5. Inpatient Discharge Summary	<input type="checkbox"/>
6. Original medical bills and medical leave certificates	<input type="checkbox"/>
7. Copies of wage payment vouchers for 12 months prior to date of accident (e.g. accident in January 2019, require wage payment voucher for January 2018 to December 2018)	<input type="checkbox"/>
8. Please indicate the number of work days per week under “Earnings of Insured Worker” of the enclosed Claim Form	<input type="checkbox"/>
9. Contract (with value) for job accident site (where accident site is not insured premises)	<input type="checkbox"/>
10. Contractual agreement between main contractor and sub-contractor (for project policy)	<input type="checkbox"/>
11. Annual WICA policy of the other party (main/sub-con) insurer covering accident at worksite (for project policy)	<input type="checkbox"/>
12. Police report (where serious accident occurs resulting in fire, explosion collapse of building, etc)	<input type="checkbox"/>
13. Traffic police report (where it is a road traffic accident)	<input type="checkbox"/>
14. Death certificate and relevant reports (where accident results in death)	<input type="checkbox"/>
15. Timesheet/Attendance/Work Schedule for the month of accident	<input type="checkbox"/>
16. Copy of Toolbox Meeting (if applicable)	<input type="checkbox"/>

Note: Additional documents may be requested as and when necessary



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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 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. of Injured Employee: _____
Mailing Address of Injured Employee: _____		Postal Code () _____
Contact No. of Injured Employee: _____	Age of Injured Employee: _____	Citizenship of Injured Employee: _____
Marital Status of Injured Employee: _____	Gender of Injured Employee: _____	Date Entered Service of Injured Employee: _____
Occupation of Injured Employee: _____		
Was the worker engaged in the occupation when the accident occurred? If No, please provide details: _____		
Is there any other policy(ies) covering the worker in respect of this accident? If No, please provide details: _____		



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Is the worker your direct employee?

If No, please provide details of direct employer:

Name of Direct Employer:

Contact No. of Direct Employer:

Mailing Address of Direct Employer:

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?
If Yes, please provide details:

Was anyone supervising the employee at the time of the accident?
If Yes, please provide details:

Describe how the accident occurred:

Name of Supervisor:

Designation of Supervisor:

Mailing Address of Supervisor:

Postal Code ()

Contact No. of Supervisor:

Was the accident reported to the Ministry of Manpower (MOM)? (Attach a copy of the MOM i-Report)
If Yes, date reported:



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

Responsibility/Witness (es)

Was another person, in your opinion, responsible for the accident?

If Yes, please provide details:

Name:

NRIC/FIN No.:

Home Address:

Postal Code

(

)

Office Address:

Postal Code

(

)

Reason(s) why he/she was responsible:

Was there a witness(es) to this event?

If Yes, please provide details:

Name of Witness:

NRIC/FIN No. of Witness:

Home Address of Witness:

Postal Code

(

)

Office Address of Witness:

Postal Code

(

)

Occupation of Witness:

Contact No. of Witness:

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:



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Is the worker still undergoing medical treatment? 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?	

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 inquiry, 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 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: _____ Details: _____

Month	Gross Monthly Earning (excluding bonuses)	Annual Wage Supplement
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
	S\$	S\$
Total Average	A1 S\$	A2 S\$
Total Average Earnings (A1 + A2)		



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Payment Details

Please select the claim payment mode.

- For payment by cheque
- For payment by direct transfer into Policyholder's bank account.

Please provide a copy of your bank account statement showing the Name of Bank, Name of Account Holder and Account Number for your initial claim submission.

Full name (as shown in the bank account): _____	Nationality: _____
Name of Bank: _____	Bank Account Number: _____

- For payment by PayNow

Please provide us with a copy of NRIC for verification purpose. The claim reimbursement can only be made to the Insured/Claimant and will be paid via transfer to your bank account linked by PayNow NRIC/FIN ID by default. Please ensure that you have signed up for PayNow with your bank by linking it to your NRIC/FIN ID.

NRIC/FIN ID: _____	UEN: _____
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INDEMNITY

The Company shall not be liable for any loss incurred by you as a result of you providing the Company with incorrect bank account details for the payment of your claim.

DECLARATION

- a) 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.
- b) I authorise the release of any medical information necessary to process this claim.
- c) I/We have read & agreed entirely to all terms in Liberty's Data Protection Policy, available on request & also at www.libertyinsurance.com.sg/data-protection-policy, both now & in advance as it may be amended from time to time.

To enquire on the claim status, please call us at 1800-LIBERTY (5423789) or email wica_claims@libertyinsurance.com.sg.

Date

Signature of Claimant

Date

Signature of Policyholder
(Company stamp, if applicable)

