

PERSONAL ACCIDENT (PA) CLAIM FORM

Agency/Broker: _____

PA Policy No.: _____

IMPORTANT

1. This form is issued and/or accepted without admission of liability.
2. The insured must complete this form fully and accurately.
3. The list of documents required is not exhaustive and we reserve the right to request from you any additional information/documentation, as necessary.

1. Particulars of Insured

Name of Insured (<i>Company</i>)		GST Registered	<input type="checkbox"/> Yes <input type="checkbox"/> No
		GST No. (<i>if Yes</i>)	
Company Address		Date of Enrolment/Cover	
Contact Person		Nature of Business	
Contact No. (HP)	(O)	Email	
Name of Main Contractor (<i>if applicable</i>)		Name of Sub-Contractor (i.e. direct employer) (<i>if applicable</i>)	
Name of Person who lodged report (<i>as in NRIC/Passport</i>)		NRIC/Passport/WP/FIN No.	
Contact No. (HP)	(O)	Total No. of Employees	Occupation

2. Particulars of Injured Person

Name (<i>as in NRIC/Passport</i>)		NRIC/Passport/WP/FIN No.	
(a) Local Residential Address		Date of Birth (<i>dd/mm/yyyy</i>)	Marital Status
		Nationality	
(b) Residential Address in your Home Country		Relationship to Insured	
		Occupation	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Employment	Occupation
Contact No. (H)	(O)	(HP)	Email

3. Details of Accident

Date/Time of Accident		Place of Accident	
Was the injured person drunk or under drugs at the time of the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Will there be any more bills to be submitted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Details of how accident occurred and what the injured person was doing at that time (<i>attach accident report for our references</i>)			
Nature and Extent of injury sustained (<i>including type of injury and part of the body injured</i>)			

Name and address of any witness(es)	
Date Returned/Expected to return to work (dd/mm/yyyy)	
Is this a job-related accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the injured person previously suffered from an injury to the same part? If Yes, please give details	<input type="checkbox"/> Yes <input type="checkbox"/> No
If still receiving treatment, please state nature of treatment and next date of scheduled medical appointments	
Death (if applicable)	
In what capacity are you claiming the insurance? Please state your relationship with the deceased.	
Any surgical operation performed? If Yes, please state below	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital Admission Date (dd/mm/yyyy)	Name of Hospital Admitted
Hospital Discharge Date (dd/mm/yyyy)	
Date Surgery Performed (dd/mm/yyyy)	Class of Ward
Surgery Details (Please provide details on surgery performed and attach "ATTENDING PHYSICIAN'S STATEMENT" for our review)	
What is the estimated period of incapacity?	
OTHER INSURANCE OR COMPENSATION	
Is the injured person presently also insured for medical insurance under another Insurance Company?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please provide information below:	
Name of Insurance Company	
Type of Policy	
Policy No.	
Documents to be submitted	<input type="checkbox"/> Attending Physician's Statement
	<input type="checkbox"/> Original Invoice & Receipt
	<input type="checkbox"/> Inpatient Discharge Summary
	<input type="checkbox"/> Medical Report
	<input type="checkbox"/> Police Report
	<input type="checkbox"/> Death Certification / Letter of Administration
	<input type="checkbox"/> Medical Certificate
	<input type="checkbox"/> Copy of Patient's Passport/Work Permit/Identity Card
<input type="checkbox"/> Coroner's Findings/Post Mortem Report/Toxicological Report	
REMARKS:	

DECLARATION

- i. I declare that the above statements and answers are true and complete to the best of my knowledge and belief.
- ii. I hereby authorize any hospital, physician, person or organization to disclose when requested to do so by ECICS Limited, all information with respect to any illness, injury, medical history, consultations, prescription or treatments and copies of all hospital or medical records.
- iii. I authorize to disclose information (including health information) about the insured person if this claim is made on behalf of them.
- iv. A photocopy of this authorization shall be considered as effective and valid as the original.

NOTICE: Personal Data Protection Policy

We/I understand, acknowledge, agree and consent that:

- a) ECICS Limited (the "Insurer") is permitted to collect, use, disclose and/or process my personal data/personal information set out in this Claim Form and any other personal information provided by me or possessed by ECICS Limited (collectively the "Personal Information") and disclose and transfer such Personal Information to the Insurers' lawyers/law firms, Insurers' doctors, the Monetary Authority of Singapore and any relevant government agency/authority (such as the police), for the purpose(s) of:
 - (i) processing, handling and/or dealing with my claims including the settlement of the claims and any necessary
 - (ii) investigations relating to the claims;
 - (iii) investigating my claims
 - (iv) carrying out and/or dealing with my instructions or responding to any enquiries by me;
 - (v) administering my claims (including the mailing of correspondence, statements, invoices, reports or notices to me, which could involve disclosure of certain personal data about me to bring about delivery of the same as well as on the external cover of envelopes/mail packages); and/or
 - (vi) complying with applicable law in administering, processing, handling and/or dealing with my claims.

(collectively the "Purposes")

- b) the Insurers' lawyers/law firms, insurer's doctors, adjuster may/are permitted to collect, use, disclose and/or process my Personal Information for one or more of the above Purposes; and
- c) my Personal Information may/can be disclosed by any of the Insurers and/or GIA to their third party service providers or agents (including their lawyers/law firms), which may be sited outside Singapore, for one or more of the above Purposes.

Signature of Policyholder

Signature of Patient

Date:

Date: