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WORK INJURY COMPENSATION (WIC) CLAIM FORM

Agency/Broker: _____
WIC 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 (Company)		GST Registered : ☐ Yes ☐ No If Yes, please provide GST No.:
Company Address		Date of Enrolment/Cover:
Contact Person		Nature of Business
Contact No. (HP)	(O)	Email
Name of Main Contractor (if applicable)	Name of Sub-Contractor (i.e. direct employer) (if applicable)	
Name of Person who lodged report (As in NRIC/Passport)		NRIC/Passport/WP/FIN No.
Contact No. (HP) (O)	Total No. of Employees	Occupation

2. Details of Injured Person

Name (As in NRIC/Passport)			NRIC/Passport/WP/FIN No.
(a) Local Residential Address (b) Residential Address in your Home Country			Date of Birth (DD/MM/YY) Marital Status Nationality
Gender ☐ Male ☐ Female	Date of Employment		Occupation
Contact No. (H)	(O)	(HP)	Email
What were the duties of the injured employee?			
No. of days worked per week by injured employee			Gross Monthly Earnings for 12 months preceding date of accident

Is the injured employee in your direct employment? ☐ Yes ☐ No
If no, please provide:
Name and Address of Employer: _____

Name of Insurance Company and Policy Schedule: _____

B) ACCIDENT DETAILS

Date/Time of Accident	Place of Accident

Describe how it happened?		
Was the injured employee under the influence of drinks or drugs at the time of the accident?	☐ Yes	☐ No
Are you satisfied the injured employee has met with a bonafide accident of employment?	☐ Yes	☐ No
Was the accident reported to Ministry of Manpower (MOM)? *If yes, when did you report? (To enclose form A / I – Report)* *If no, please provide reason for non-reporting*	☐ Yes	☐ No
Did the injured employee comply with safety regulations? *If no, please provide details*	☐ Yes	☐ No
Has the injured employee attended any safety precaution briefing prior to accident? *If yes, please provide last date of briefing*	☐ Yes	☐ No
Are there any witness(es) to this accident? *If yes, please provide name and address of the witnesses*	☐ Yes	☐ No
Was there any investigation conducted by the police or related authorities after the accident? *If yes, please provide a copy of the investigation report*	☐ Yes	☐ No
Was the injured employee guilty of any misconduct or disobedience to orders or rules? *(i.e. was the injured employee wearing safety boots or safety harness etc?)*	☐ Yes	☐ No
C) INJURY DETAILS		
Please advise whether the injured employee had any previous injury under your employment? *If yes, please provide details*	☐ Yes	☐ No
Are there any pre-existing conditions when he/she was employed? *If yes, please provide details* Would such infirmity have contributed towards this accident?	☐ Yes ☐ Yes	☐ No ☐ No
Describe the type and extent of injuries (i.e. fracture of hand, amputation of toe, sprain to back etc)		
Where was the injured employee medically examined / treated?	Date of Discharge	
Was the injured employee hospitalized? *If yes, please provide name of hospital*	☐ Yes	☐ No

What is the doctor's diagnosis?
What is the estimated Period of Incapacity?
Did the injured employee attend any outpatient treatment after the accident? ☐ Yes ☐ No *If yes, please provide name of hospital or clinic*
How many days of Medical Leave was given from time of accident? (a) Hospitalization Leave: (b) Outpatient Leave:
Has the injured employee returned to work? *If yes, please advise date of return*
Is the injured employee able to do partial work? ☐ Yes ☐ No

D) ADDITIONAL PARTICULARS FOR FATAL CASES ONLY

(Please furnish a copy of Post Mortem Report, Death Certificate and Police Report)

Does the deceased have any dependants? ☐ Yes ☐ No *If yes, please state names, addresses, relationship, gender, age and occupation (if any) on a separate piece of paper.*
Date / Place of Death Inquiry

E) DECLARATION OF EARNINGS

Statement of earnings of the injured employee earned in the present employment for the twelve months immediately prior to the date of this accident, or earning earned during such shorter period as he may have been in the employer's service.
"Earnings" include allowances, wages, bonuses, annual wage supplement and overtime payments but does not include travelling allowances, employer's CPF contributions or pensions or monies paid to cover any special expenses incurred by the employee by nature of his employment.
Note: If the injured employee has been absent from work at any time during the period of his employment, please state the period and cause.

Year	Month	Gross Monthly Earnings S$)	Bonus, Overtime, Allowances (S$)
	TOTAL		
	Average		

Indicate the number of working days per week: 5-day / 5.5-day / 6-day	Others, please state

F) OTHER INSURANCE OR COMPENSATION

Do you have any other Work Injury Compensation Policy? ☐ Yes ☐ No

If Yes, please provide information below:

Name of Insurance Company:
Policy No.:

REMARKS:

SUPPORTING DOCUMENTS

1. Copy of iReport to MOM
2. Copy of Work Permit / Employment Pass if the worker is foreign national
3. Original Medical Bills and Original Medical Certificates
4. Copy of Discharge Summary, if applicable
5. Copy of wage vouchers for the period of 12 months preceding the accident
6. Medical Report (if any)
7. Police Report (if any)
8. Investigation Report

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. 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 Insured Person/Employee

Signature of Employer/Company's Stamp

Date:

Date: